

V SMILE DENTAL STUDIO / Lab Sheet

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Doctor:

Clinic:

Date Prepared:

Date Due (by 5pm)

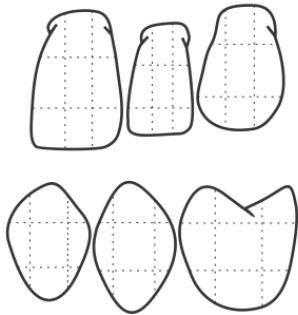
Patient Name:

Age :

Gender: Male / Female

Shade Details

Core Shade _____



Shade _____

Specific Instructions

Restoration Type (Please circle)

Zirconia

Special tray (Implant)

Lithium Disilicate/ Emax

Splint

Porcelain Fused to Metal

Night Guard / Sport Guard

Full Metal Crown (Precious/Non-precious)

Clear retainer

PMMA Crown

Others _____

If no occlusal clearance

Adjust opposing

Metal Occlusal

Transfer coping

Call Dentist

PFM Design:

Full Porc.



L Band



L Band F Collar



Full Metal L



Full Metal L F Collar



Pontic Design:

Full Ridge



Partial Ridge



No Ridge



Point Contact



No Contact



***Please follow universal precautions of sterilization, disinfection, and barrier techniques. Thank you. ***