



ERAMIC
DENTAL LABORATORIES LTD.

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Dr. _____

DATE REQUIRED: _____

PATIENT'S NAME: _____

R _____

PLEASE INDICATE CASE REQUIREMENTS BELOW

A.	METAL	GOLD	<input type="checkbox"/>	SEMI-PREC. (NOBLE)	<input type="checkbox"/>	NON-PREC.	<input type="checkbox"/>		
B.	OCCLUSION	METAL	<input type="checkbox"/>	PORCELAIN	<input type="checkbox"/>				
C.	CENTRIC CONTACT	FOIL RELIEF	<input type="checkbox"/>	POSITIVE CONTACT	<input type="checkbox"/>	CUSP FOSSA	<input type="checkbox"/>		
D.	LATERAL EXCURSION	CUSPID GUIDANCE	<input type="checkbox"/>	GROUP FUNCTION	<input type="checkbox"/>				
E.	MARGIN ADAPTATION	EXACTLY TO FINISH LINE	<input type="checkbox"/>	SLIGHT OVEREXTENSION	<input type="checkbox"/>				
F.	LABIAL MARGIN	FINE METAL COLLAR	<input type="checkbox"/>	PORCELAIN TO MARGIN	<input type="checkbox"/>	PORCELAIN BUTT MARGIN	<input type="checkbox"/>		
G.	PONTIC DESIGN	1. HARMONY 	<input type="checkbox"/>	2. CONE 	<input type="checkbox"/>	3. HYGENIC 	<input type="checkbox"/>	4. RIDGELAP 	<input type="checkbox"/>
H.	CONTACTS (EMBRASSURES)	1. BROAD 	<input type="checkbox"/>	2. NORMAL 	<input type="checkbox"/>	3. POINT 	<input type="checkbox"/>		

I. SHADE _____

