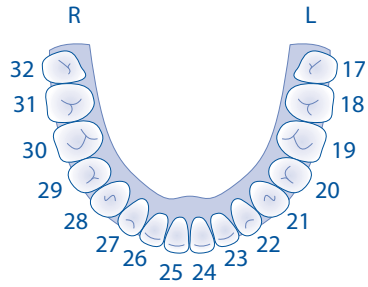
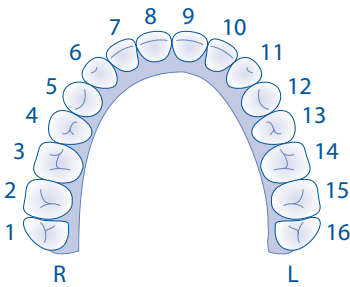


Practice Name / Dr. \_\_\_\_\_

Patient \_\_\_\_\_ Date \_\_\_\_\_

Shade	Stump Shade	Age	Try-in	Finish	Due date
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- Please send all clinical photos to: [photo@dickermantental.com](mailto:photo@dickermantental.com)
- Implant information required (*when applicable*)
- Stump shade on anterior e.max
- Restorative material:  Zirconia  e.max  PFM



Signature \_\_\_\_\_

License # \_\_\_\_\_