



620 ALDEN RD. SUITE 201
MARKHAM ON, L3R 9R7

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FROM:

DR: _____ Date: _____

Address: _____ Phone: _____

City/Prov: _____ Sex: M F Age: _____

Patient: First Name: _____ Last Name: _____

Try-In: Date Required _____ Time Wanted: _____ AM PM

Finish: Date Required _____ Time Wanted: _____ AM PM

E.	PONTIC DESIGN	1 HARMONY	2 CONE	3 HYGIENIC	4 RIDGLAP
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.	CONTACTS [EMBRASSURES]	1 BROAD	2 NORMAL	3 POINT	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SHADE					

PFM CROWN DESIGN

- Porcelain Buccal Margin
- Porcelain 360° Margin or Custom
- Metal Margin Lingual Only
- Metal Occlusal
- Metal Island

AESTHETIC CHECKLIST FOR BEST RESULTS

- Pre-op Study Models
- Post-op Temp. Models
- Wax-up Models
- Detailed Description of Modifications from Study Models to Final
- Stump Shade
- Final Shade
- Stick Bite
- Smile Selection
- Photos

Professional Signature: _____