GNATHODONTICS, LTD

Your Full Service Dental Laboratory

IMPLANT FIXED RESTORATIVE

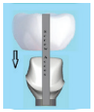
CAD/CAM ABUTMENT DESIGN INSTRUCTIONS

Tooth	Implant Type	Platform Diameter	Titanium	Gold Hue Ti	Zirconia	Subgingival Depth (Use + For Supragingvial) B/F	M	D	L	Tissue Displacement (See Options Below) 1	2	3
If none are selected the following defaults will be used ↓												
*	Anterior Defaults		Lab To Decide			1.5	0.5	0.5	0		✓	
*	Posterior Defaults		✓			1.0	0.5	0.5	0		✓	

CAD/CAM
ABUTMENT / CROWN TYPE (CHECK ONE)

☐ 
Cement-Retained

☐ 
Screw-Retained
One Piece Design

☐ 
Screwmentable
Two Piece Design

☐ Lab to Cement
☐ Dr. to Cement *

☐ CAD/CAM Abutment *
☐ Prefabricated Abutment

RESTORATION TYPE

Tooth #

____ IPS E.Max
____ Porcelain Lyered to Zirconia (PFZ)
- ☐ Gnatho Brand layered
- ☐ Lava layered

____ Lava Esthetic Full Contour
____ Full Contour Zirconia (FCZ)
- ☐ Gnatho Brand
- ☐ Bruxzir

____ Porc. Fused to Metal (PFM)
- ☐ High Noble
- ☐ Noble

____ Flat Rate Noble PFM
(cement retained CAD abutment only)
____ Full Cast (FCC)
- ☐ High Noble
- ☐ Noble

____ Layered Composite/Ceramage
____ Temporary Crown Regular
____ Long-Term Temp w/Metal Support

TISSUE DISPLACEMENT

1	2	3
Anatomical	Moderate	None

☐ Design review needed
(provide email in address section)

☐ Lab to order all components for the case *
- ☐ Use only parent company parts *
- ☐ Use most economical parts

☐ Lab to fax or email list of components for dental office to order. Scheduling will not start until parts are received at lab.

Whenever possible include a pre-op cast to aid in design of CAD/CAM abutments.

* **Indicates default selections that will be used if nothing is selected**

Dr._____

Address_____

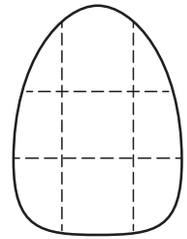
City_____ State_____ Zip_____

Phone (_____) _____ Fax (_____) _____

Email_____ ☐ Call Doctor Re: Case

RETURN DATE _____/_____/_____

DELIVERY TIME ☐ AM *(before noon)* ☐ PM *(before 5pm)* ☐ Exact time *(only if needed)* _____



PATIENT NAME _____

☐ Male ☐ Female Age_____ Shade_____

INSTRUCTIONS

CHECK ALL THAT APPLY

- ☐ Porcelain Shoulder: 180/360
- ☐ 360 degree, No Metal Showing
- ☐ 180 degree, Lingual Metal Collar
- ☐ 360 degree Metal Collar
- ☐ Metal Occlusion
- ☐ Return for Die Trim
- ☐ Metal Try-In
- ☐ Bisque Try-In

Send Supplies:
- ☐ Boxes
- ☐ Prescriptions
- ☐ Shipping Labels

Signature Of Dentist_____

License#_____Date_____

Payment for laboratory work is due 30 days after the invoice date. A service charge of 1.5% per month will be charged on past due accounts. Accounts with balances over 60 days will be automatically placed on COD.

LABORATORY WORK AUTHORIZATION (must be retained by dentist & lab for 2 years)