



Date _____ Return Date _____

DR _____

Patient _____ Gender _____ Age _____

Tooth # _____ Shade _____ Custom _____ Stump _____

Implant System _____ Full-Cast PFM

Size _____ Zirconia: PFZ

OEM FDA Cert. FCZ Basic Aesthetic

Lithium Disilicate:

Layered Full Contour

Instruction _____

Dr. Signature _____ Dr. License _____

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