

# IMPLANT AND SURGICAL STENT PRESCRIPTION



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OREC	DIS	PREP	WX	FIN	Pour _____ Trim _____ Art _____ Dupe _____	<input type="checkbox"/> B <input type="checkbox"/> DENT <input type="checkbox"/> I <input type="checkbox"/> SM <input type="checkbox"/> O <input type="checkbox"/> BF <input type="checkbox"/> M <input type="checkbox"/> ART <input type="checkbox"/> BP <input type="checkbox"/> _____
Pan #	Rec. Date		Invoice #			

Case #	Articulator #	Note for Doctor	Case #	Schedule
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Due by 5:00 p.m.	Ship to Referral Yes / No	Bill to Referral Yes / No
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Doctor _____ Address _____ City _____ State _____ Zip _____ Phone _____ Fax _____ Patient Name _____	Referral Doctor _____ Address _____ City _____ State _____ Zip _____ Phone _____ Fax _____
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Tooth #	Implant Type	Platform Diameter	Titanium Abutment w/ Provisional	Titanium Abutment w/ PFM Noble	Zirconia Abutment w/ Provisional	Zirconia Abutment w/ All Ceramic Crown

## IMPLANT STENTS

### Required

Models / Impression / Bite Records

### Appliance Type

**Clear Acrylics Precessed Denture or Surgical Stent**

Implant location site(s) \_\_\_\_\_  
 Drill guide holes Yes / No  
 Guide hole 2mm (most requested) Other Size \_\_\_\_\_mm  
 Fill holes w. radio-opaque material Yes / No  
 Titanium guide sleeves Yes / No

**Radio Opaque Acrylic Denture**

Simplant Method : Teeth 20% barium - base 10% barium  
 Alternate Method: Teeth 10% barium - base no barium

**Clear Hollow Formed Stent**

Stent thickness 1mm / 1<sup>1/2</sup> mm  
 Implant location site(s) \_\_\_\_\_  
 Coat inside with barium Yes / No

**Diagnostic Wax-up: Teeth #s:** \_\_\_\_\_

OK to use denture teeth in edentulous areas? Yes / No

**Replace Missing Teeth prior to Fabrication** Yes / No

Bone replacement site location: \_\_\_\_\_

	B/F	M	D	L
Artistic's Standard Margin Depth in mm	1.0	.75	.75	.50
Specify if Depths are to be Altered				
Shade				

Net amount of invoice is due within 30 days of receipt or order. All balances beyond 30 days are subject to a 1<sup>1/2</sup>% Finance charge. I agree to pay reasonable attorney's fees and collection costs if this account is referred for collection.

DOCTOR'S SIGNATURE \_\_\_\_\_ LIC. NO. \_\_\_\_\_

Net amount of invoice is due within 30 days of receipt of order. All balances beyond 30 days are subject to 1 1/2% Finance Charge per month not to exceed 18% per year. I agree to pay reasonable attorney's fees and collection costs if this account is referred for collection.