Kierland
SMILE DESIGN

Date: _____

Aesthetic RX Dental Lab

Dr. _____ License #_____

Patient _____ M/F _____ Age _____

Returning Date: _____

Type of Restoration

O	E-Max Press	O	E-Max Press to Zirconia
O	Aesthetic Zirconia	O	Zirconia
O	Minimal/No Prep Veneers	O	Diagnostic Wax-Up

Goals for Case

O	Change Vertical Dimension	O	Feminize Smile	O	Will the opposing be restored?
O	Youthful Smile	O	Move Midline (To patient's **R** or **L**)	O	Other:_____
O	Lengthen Teeth	O	Close Diastema		

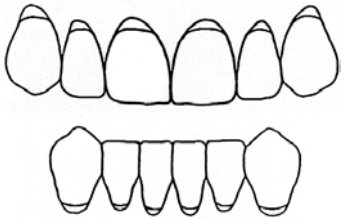
Ok to relieve opposing?	Yes	No	Ok to relieve prep?	Yes	No
			Reduction copings?	Yes	No

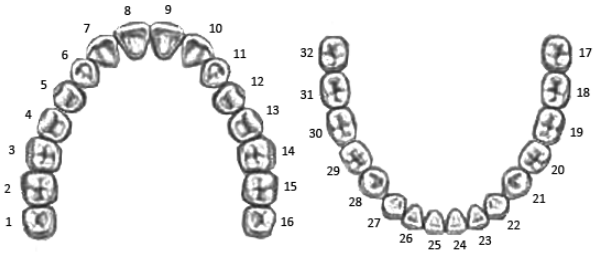
Items Included With Case

O	Bite Registration with/without Stick	_____	O	Opposing Impression	_____
O	CR Bite Registration	_____	O	Photos / Email	_____
O	Facebow Transfer Jig MFG	_____	O	Pre-op Models	_____
O	Impression of Provisionals	_____	O	Stick Bite	_____
O	Master Impressions/Qty	_____	O	Diagnostic Wax-up	_____

Pick Up Call: 480.215.3956 Email: office@kierlandsmile.com

White Copy-Lab





Shade _____ **Prep Shade** _____

CEJ – CEJ: #_____ to # _____ , Pre-op_____mm, Final_____mm

Length from Margins (mm)	Centrals_____mm	Laterals_____mm	Canines_____mm	
Incisal Translucency	Minimal 0.5	Moderate 1.0	Maximum 1.5	
Shade of Translucency	Clear	Frosted	None	
Surface Finish	Low Gloss	Medium Gloss	High Gloss	
Outline Shape	Provisional Model	Wax-Up	Smile Catalog	Pre-Op Model
Surface Texture	High	Medium	Light	Smooth

Notes:_____