Restorative Rx: Full-Arch Implants

ROE Dental Laboratory
800-228-6663 | info@roedentallab.com | www.roedentallab.com
Main Laboratory: 7165 E Pleasant Valley Rd, Independence, OH 44131

Please ✓ applicable boxes. Required fields indicated with asterisk (*). ROE standards (O) apply if no selection is made.

IMPLANT
Implant Line & Platform* _____

MATERIAL

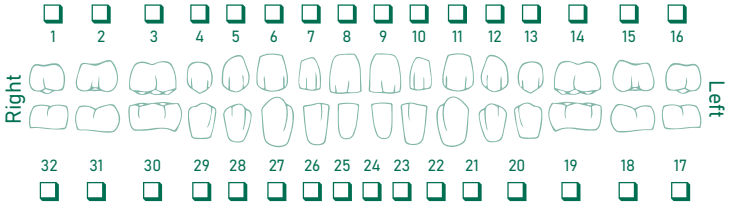
	DAYS IN LAB
☐ TLZ-IB Full Zirconia w/ Ti Bases	11
☐ TLZ-IB Full Zirconia w/o Ti Bases *Nobel compatible MUA only*	11
☐ NobelProcera® Full Zirconia	11
☐ Ultra Nano w/ Trilor® Bar	11
☐ Full Acrylic Denture Teeth Wrap w/ Ti Bar	11
☐ iJIG™ (Fit Verification w/ Teeth)	6
☐ Printed Try-In Prototype	6
☐ PMMA Long-term Provisional	6

TOOTH DESIGN

☐ Midline Shift *(to patient's left/right)*	____mm Left	____mm Right
☐ Move Incisal Edge Maxilla	____mm Apical	____mm Incisal
☐ Move Incisal Edge Mandible	____mm Apical	____mm Incisal
☐ Move Max. Plane of Occlusion	____mm Up	____mm Down
☐ Move Anteriors Maxilla	____mm Facially	____mm Palatally
☐ Move Anteriors Mandible	____mm Facially	____mm Palatally
☐ Desired Central Dimensions	____mm Length	____mm Width

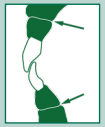
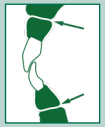
☐ Change Tooth Shape as explained in instructions
☐ Horizontal Change Plane (send photos)
Bite Classification ☐ I ☐ II ☐ III

Please ✓ teeth numbers to omit



TISSUE TRANSITION DESIGN*
☐ Copy Try-In Design Exactly
☐ Copy Try-In Design, Following Instructions Below

Hygienic w/ Ridge Contact	Hygienic / Highwater	Maxillary Flange
☐ Upper	☐ Upper	☐
☐ Lower	☐ Lower	


TOOTH SHADE* _____

OCCLUSAL STAINING
☐ None O
☐ Light
☐ Medium
☐ Dark

TISSUE SHADE
☐ Pink
☐ Lighter Pigment O
☐ Darker Pigment
☐ Use Enclosed Sample

DESIGN & ESTHETICS
ROE will use available tools and resources to mimic Dr.'s request.
☐ Copy Surgical Prosthetic
☐ Copy iJIG™
☐ Copy Printed Try-In
☐ Copy Conversion Prosthetic
☐ Copy RAPID Appliance
☐ Use Original SmileSIM®
☐ Denture Tooth Set-Up

NEW RECORDS TO USE
☐ New Bite Registration
☐ New Photo
☐ New Impression
☐ New Tissue Impression
☐ Returned Articulation

GRAMMETRY
Type: ☐ OptiSplint ☐ Imetric ☐ PIC
Screw: ☐ DESS 19.018
☐ Dan Rosen ____mm
☐ Vortex 1.4mm
☐ SIN
Coping: ☐ Yes ☐ No
Healing Collar Brand: _____
Who Fabricates: ☐ ROE ☐ Dr
Implant Brand: _____
MUA Brand: _____

Doctor Name* _____ Date _____
Address* _____
City* _____ State* _____ ZIP* _____
Email* _____ Phone* _____
Patient Name* _____ Age* _____ ☐ Male ☐ Female
RETURN BY 5:00 P.M. ON _____ ☐ Expedite *fees apply*
☐ **CALL ME**
DO YOU NEED? ☐ Rx ☐ Days in Lab ☐ Boxes ☐ Shipping Labels

Instructions
Please indicate Dr. & patient goals*

Signature* _____ **License #*** _____

The person signing this work order accepts responsibility for payment and agrees to pay all collection costs including attorney's fees. A 1.5% (18%/yr.) finance charge will be added to all balances due over 30 days.

For the most up-to-date Rx & forms, please visit **www.roedentallab.com/forms**