COMPREHENSIVE CARE & ESTHETIC CASES RX

This form has been created to aid us in working as a team to create an ideal, functional, and esthetic diagnostic blueprint for this patient.

PATIENT INFORMATION

Patient Name: _____ Age: _____

Date Sent: _____ Date Due Back: _____

Trial Smile (Additive) ☐ OR Diagnostic (Prepped to Ideal) ☐

Requested photographs for all mock-ups: Full face smile shot, full face retracted shot, lips in repose, duchenne smile

DETAILED TOOTH POSITION

Maxillary Central Incisors:

Ideal Length _____mm Width_____mm Shape_____

Comments _____

_____

OCCLUSAL FUNCTION

☐ Models are mounted in CR and have been trial-equilibrated
☐ Models are mounted in CR and have NOT been trial-equilibrated
☐ Models are mounted in maximum intercuspation/CO
☐ NM Occlusion
☐ Deprogrammed Anterior Jig

Comments _____

OCCLUSAL VERTICAL DIMENSION

☐ Keep the vertical dimension the same as provided by record
☐ Open to specific dimension _____ mm
☐ Open the vertical dimension beyond the point of initial contact
☐ Open vertical dimension for ideal restorative space and proportion

Comments_____

_____

ADDITIONAL CASE INFORMATION

_____

_____

_____

_____

_____

TEETH TO BE RESTORED

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

FINAL RESTORATIONS

☐ Zirconia
☐ Lithium Disilicate

Shade _____

TREATMENT GOALS

Description of patient's desires _____

_____

_____

_____

GINGIVAL TISSUE LEVELS

☐ Acceptable ☐ Alteration Planned

Teeth to be altered:

_____ # _____ # _____ # _____ # _____ # _____

Comments _____

_____

_____

ANTERIOR GUIDANCE

☐ same _____
☐ steeper_____
☐ flatter _____
☐ cuspid rise _____
☐ anterior group function - which teeth_____
☐ other _____

Comments_____

_____

MEASUREMENTS

Please mark models with points of measurement.
Please provide the tooth numbers and measurements below.

Right Posterior _____ / _____ _____ mm

Anterior _____ / _____ _____ mm

Left Posterior _____ / _____ _____ mm

DOCTOR'S SIGNATURE _____

DOCTOR'S LICENSE NUMBER _____