

FIXED Prescription Form



APEX DENTAL

Laboratory, Inc.

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ALL FIELDS MARKED IN RED ARE REQUIRED
Incomplete forms will automatically be put on hold

Doctor _____

Office Location _____

Patient Name _____

Email _____ Age _____

Telephone _____ Gender _____

Date Sent _____

Photos emailed to photos@apexdentallabne.com

1. Select One Type of Delivery:

<input type="checkbox"/> DELIVER CASE BEFORE PATIENT APPOINTMENT Date of Patient Appt. ____/____/____ Time of Patient Appt. ____:____	<input type="checkbox"/> FOLLOW IN-LAB SCHEDULE (Patient will be appointed after receiving case).
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


2. Check Box To Pick Your Product

ALL-CERAMIC	PORCELAIN-FUSED-TO-METAL	MISCELLANEOUS
<input type="checkbox"/> Crystal Zirconia Anterior - (Full Contour) <input type="checkbox"/> Crystal Elite Zirconia - (Full Contour) <input type="checkbox"/> w/Cutback and Layer <input type="checkbox"/> *E.max Full-Contour <input type="checkbox"/> w/Cutback and Layer <input type="checkbox"/> *E.max Veneer	<input type="checkbox"/> Base Metal White <input type="checkbox"/> Noble White <input type="checkbox"/> High-Noble White <input type="checkbox"/> High-Noble Yellow	<input type="checkbox"/> Diagnostic Wax-Up <input type="checkbox"/> Temporary Crown/Bridge <input type="checkbox"/> Other _____
SCREW-RETAINED	FULL CAST CROWN	IMPLANT ABUTMENT
<input type="checkbox"/> e.max Screw-Retained <input type="checkbox"/> NobelProcera® ASC <input type="checkbox"/> Crystal Elite FCZ <input type="checkbox"/> w/Cutback and Layer <input type="checkbox"/> PFM Screw-Retained: <input type="checkbox"/> Non-Precious <input type="checkbox"/> Noble	<input type="checkbox"/> Base Metal Yellow <input type="checkbox"/> Noble White <input type="checkbox"/> Noble Yellow <input type="checkbox"/> High-Noble Yellow	<input type="checkbox"/> Stock <input type="checkbox"/> Custom Milled Zirconia <input type="checkbox"/> Custom Milled Titanium <input type="checkbox"/> Custom Cast Abutment <input type="checkbox"/> Brand Pref. _____

3. Customize Your Product

Shade: _____	Stump Shade: _____	Tooth Number: _____
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4. Design Your Product (Optional):

<p>COLOR MAPPING</p>  	<p>COLOR MAPPING</p> <p>Incisal Translucency <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None</p> <p>Cervical Warming <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None</p> <p>Surface Texture <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None</p> <p>Occlusal Stain <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None</p> <p>Degree of Hypocalcification <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None</p> <p>Mamelons <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None</p>
<p>PONTIC DESIGN</p> 	

Additional Instructions (Use back if needed) _____

Doctor Signature _____ License # _____

Terms: Invoices are due in full net 30 days from invoice date. If not paid in 30 days, account is subject to 1.5% finance charge per month of unpaid balance (approximately 18% annual percentage rate). If not paid within 60 days, attorney fees, cost of collection and continuing interest shall be added.