CASE SUBMISSION FORM

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CASE # _____ **DATE** _____

DOCTOR & PRACTICE INFORMATION

DOCTOR NAME _____ **PRACTICE NAME** _____

PHONE _____ **EMAIL** _____ **ACCOUNT # (IF EXISTING)** _____

PATIENT INFORMATION

PATIENT LAST NAME _____ **PATIENT FIRST NAME** _____ **PATIENT ID / CHART #** _____

DATE OF BIRTH (MM/DD/YYYY) _____ **DUE DATE REQUESTED (MM/DD/YYYY)** _____

CASE TYPE

- ☐ Full-Arch / All-on-X
- ☐ Implant Crown & Bridge
- ☐ CAD/CAM Crown & Bridge
- ☐ Removable / Overdenture
- ☐ Cast Partial
- ☐ Full Denture
- ☐ Other

TOOTH / ARCH INFORMATION

TOOTH NUMBER(S) / ARCH _____ **IMPLANT SYSTEM / PLATFORM** _____

ABUTMENT TYPE _____ **SCREW / CEMENT RETAINED** _____ **OPPOSING** _____

MATERIAL & SHADE

RESTORATION MATERIAL _____ **SHADE / GUIDE** _____ **STUMP SHADE** _____

GINGIVAL SHADE _____ **SPECIAL CHARACTERIZATION NOTES** _____

ENCLOSURES / SUBMISSION METHOD

- ☐ Digital Scan (.STL)
- ☐ PVS Impression
- ☐ Stone Model
- ☐ Bite Registration
- ☐ Opposing Model/Scan
- ☐ Photos Enclosed
- ☐ Existing Appliance
- ☐ Wax Rim

SPECIAL INSTRUCTIONS / NOTES