

Beautiful Anteriors



KING DENTAL
ARTS

ANTERIOR SMILE DESIGN FORM

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*"Highly Esthetic and
Functional Restorations"*

Patient _____ Date _____

Male Female Age _____ Photos Enclosed or e-mailed _____

Shade _____ Prep Shade _____ Tooth Numbers _____

CHECKLIST

BEFORE PREPARATION

1. Pre-op Model or Impression
2. Full Face Photo of Smile
3. Close up with Shade Guide
4. Desired Shade
5. Clear Opposing Model or Impression

AFTER PREPARATION

1. Clear Master Impression
2. Photo of Preps with Shade Guide
3. Bite
4. Completed Work Order
5. Material Selection
E-max Zirconia

Additional Instructions Patient / Doctor's Goal

Signed Dr. _____

Address _____

City _____ State _____ Zip _____

Please send: Prescription Forms Labels Boxes

Please Schedule Patient
2 Days After Due Date

DATE REQUESTED

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ACTUAL APPT.

Date _____ Time _____