



Please Fax completed form to (310) 745-5683
or enclose with your next case.

CROWN & BRIDGE PREFERENCES

Requested by _____ Date: _____ Acct. # _____

Doctor's Name: _____ Doctor's Email: _____

Office Manager: _____ Lead DA/Back Office Mgr: _____

Phone #: _____ Fax #: _____ Office Email: _____

Preferred Contact Method (Check all that applies): Phone Fax Doctor Email Office Email
 Text (Please provide Cell Phone #) _____

Dr. Signature: _____ License #: _____

Margin Preparation: Shoulder Chamfer Feather Bevel Other (Specify below)

Relief Preferences - Die Spacer: Yes (if yes, please specify how many coats) _____ No

Foil Opposing: Yes No Other (Specify below)

Paint Opposing: Yes No

Contacts: Light Medium Heavy Other (Specify below)

Metal Design: Collarless Lingual Collar Only 360 degree Collar Other (Specify below)

Staining: Light Medium Heavy

Occlusal Anatomy: Primary Secondary Match Adjacent Other (Specify below)

Occlusal Clearance: Light Open Contact Other (Specify below)

If Insufficient Clearance: Call Adjust Opposing Metal Occlusal Lingual Reduction Coping

Please Note: If margins are in question, the Lab will call to discuss.

Please Specify Additional Instructions and Preferences:
