



**Centromatix Dental Lab**  
**6600 Madison Ave. Suite #11**  
**Carmichael, CA 95608**  
**(916) 966-2300**  
**admin@centromatix.com**

Dr. \_\_\_\_\_

Patient's Name: \_\_\_\_\_

INDICATION		STEP	DATE WANTED
Complete Upper Denture <input type="checkbox"/>	Partial Upper Denture <input type="checkbox"/>	Bite Registration <input type="checkbox"/>	_____
Complete Lower Denture <input type="checkbox"/>	Partial Lower Denture <input type="checkbox"/>	Wax Try-In <input type="checkbox"/>	_____
		Finish <input type="checkbox"/>	_____

AGE	GENDER	PERSONALITY	
Actual _____	Female <input type="checkbox"/>	Masculine Personalities	Feminine Personalities
Patient's Appearance	Male <input type="checkbox"/>	Moderately Vigorous <input type="checkbox"/>	Delicate Feminine <input type="checkbox"/>
Young..... <input type="checkbox"/>		Medium Vigorous <input type="checkbox"/>	Medium Feminine <input type="checkbox"/>
Middle Age. <input type="checkbox"/>		Rugged Vigorous <input type="checkbox"/>	Active Feminine <input type="checkbox"/>
Older..... <input type="checkbox"/>			
Aged..... <input type="checkbox"/>			

AESTHETICS				DENTURE TEETH
ALAMETER _____	PAPILLAMETER _____	SHADE _____	MOULD _____	Porcelain <input type="checkbox"/>
				Acrylic <input type="checkbox"/>

OCCCLUSION
Non-Interceptive (Auto-Centric) <input type="checkbox"/>
Cusp Occlusion (Lingualized) <input type="checkbox"/>

BITE REGISTRATION
G.A Tracer & E.C.B. <input type="checkbox"/>
Wax Bite Rims <input type="checkbox"/>

EXTRAS	
Custom Trays <input type="checkbox"/>	Neutral Zone <input type="checkbox"/>

INSTRUCTIONS:

Signature: \_\_\_\_\_ License # \_\_\_\_\_

Signature \_\_\_\_\_ D.D.S.

License # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's Name \_\_\_\_\_

## le.max inVizion™

A VITA ALL-CERAMIC RESTORATION

### SHADE INSTRUCTIONS

SHADE NO. \_\_\_\_\_

#### PERSONALITY

- DELICATE
- MEDIUM
- VIGOROUS

#### GINGIVAL Intensity Saturation

- LIGHT
- MEDIUM
- HEAVY

#### INCISAL Intensity Saturation

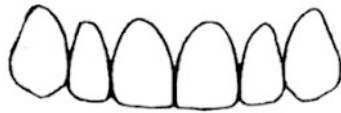
- LIGHT
- MEDIUM
- HEAVY

#### OCCUSAL STAINING

- LIGHT
- MEDIUM
- HEAVY

Please indicate the distribution of color dispersion and the desired types of characterizations

APPROXIMATE AGE: \_\_\_\_\_



- METAL TRY-IN
- FINISH
- PORCELAIN FUSED TO GOLD ALLOY
- GOLD CROWN
- PORCELAIN FUSED TO NONPRECIOUS

**R**  
TOOTH  
NUMBER

### SPECIFIC INSTRUCTIONS

NOTE: PLEASE SEND A STUDY MODEL ON ALL WORK INVOLVING ANTERIOR TEETH




DATE WANTED \_\_\_\_\_

### DESIGN INSTRUCTIONS

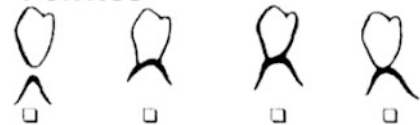
#### ANTERIOURS

-  METAL COPING
-  3/4 METAL LINGUAL

#### POSTERIOURS



-  METAL COPING ALL PORCELAIN COVERAGE
-  METAL OCCUSAL EXCLUDING BUCCAL CUSP
-  METAL OCCUSAL INCLUDING BUCCAL CUSP

#### PONTICS



- METAL TRY-IN
- METAL MARGIN
  - HAIRLINE OR \_\_\_\_\_ MM
- METAL-PORCELAIN JUNCTION MARGIN

#### MAXILLARY CUSPIDS

-  METAL COPING
-  1/4 METAL LINGUAL

Observation: These two designs have been constantly successful in the prevention of metal migration, avoiding a possible cleavage at the metal-porcelain junction.