



ambridge ceramics
 the art of precision



Dentist: _____

Address: _____

Telephone: _____

Patient: _____

Age: M F

Shape of face: Oval Round Angular

Tooth Surface: Smooth Medium Rough

Basic Shade: _____

Type: A B C

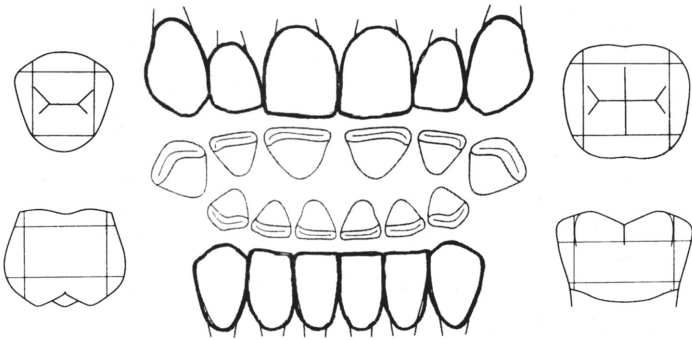
Dentine/Enamel Structure (please indicate)

Type A

Type B

Type C

Type A: Irregular distribution of translucency or translucent layer over entire labial surface.
 Type B: Translucent layer in incisal area.
 Type C: Translucent layer in the proximal and incisal area.



Date required back (please allow 10 working days) _____

am / pm

All Ceramic Composite

PFM Precious PFM Non Precious

Refer to Smile Makeover form

Refer to Diagnostic Wax-up form

Instructions: _____

FOR LAB USE ONLY

ENCLOSURES

Alginate U/L _____

Rubber U/L _____

Study models U/L _____

Bite record _____

Photo _____

Other _____

CONTRACT RECEIVED & ORDER ACCEPTED

Signed: _____ Date: _____ Job No.

Operation	Inits	Operation	Inits	Operation	Inits
Disinfection	<input type="text"/>	Models/articulation	<input type="text"/>	Die Trim	<input type="text"/>
Wax/Blockout	<input type="text"/>	Process Acrylic/vinyl	<input type="text"/>	Trim/Polish	<input type="text"/>
Metal Work	<input type="text"/>	Porcelain/Composite	<input type="text"/>	Glaze/Polish	<input type="text"/>

FINAL DELIVERABLE CHECKED AND CLEARED FOR DESPATCH

Signed: _____ Date: _____

Statements:

- 1: This custom made device is for the exclusive use of the patient named above and conforms to the relevant essential requirements set out in Annex 1 of the Medical Devices Directive (93.42/EEC).
- 2: Any relevant essential requirements that have not been met will be listed overleaf with a description with a description of the reason.
- 3: All goods are supplied in a non-sterile condition unless otherwise stated and should not be subject to extremes of hot or cold.