Diagnostic RX

WIAND DENTAL LABORATORY

Patient: _____ M | F Age: _____ Today's Date: _____

Doctor: _____ Date Wanted: _____

Address: _____ Time: **12:00 | 4:00**

Email: _____ Phone: _____

Preferred Communication: ☐ Phone ☐ E-mail ☐ Text

Hand-Waxed _____

Digital _____

Additive Only _____

Diagnostic Wax-up Prep Kit: ☐ YES ☐ NO

Length of Centrals Desired _____mm

Restore in CR or MIP

Change VDO _____mm CEJ to CEJ _____mm

Number of Units _____

Crowns or Veneers

Adjust Gingiva, Crown Lengthening _____mm

Expand Buccal Corridor: ☐ YES ☐ NO

Close Diastema: ☐ YES ☐ NO

Photos Sent ☐ YES ☐ NO

Change Midline Cant: ☐ YES ☐ NO

Change Incisal Cant: ☐ YES ☐ NO

Lengthen or Shorten Teeth _____mm

Move Midline (left-right) _____mm

Change Over Bite _____mm Over Jet _____mm

Surface Texture: ____ Light ____ Medium ____ Heavy

Change Shape: ☐ YES ☐ NO If YES Shape _____

Facebow Sent: ☐ YES ☐ NO

Special Instructions:

480.446.7063 or 833.269.1195 | 10555 N. 114th Street, Suite #101 | Scottsdale, AZ 85259 | **www.wiandlab.com**

Wiand Dental Lab, Inc.