DIGITAL DESIGNS
Dental Lab

Expect Only Excellence

Crown & Bridge Preferences

These will be your default preferences unless otherwise stated on a Rx.

Please fax the completed form to **(614) 443-7311**, email to **info@digitaldesignsdl.com** or enclose with your next case.

Date: _____/_____/_____ Phone: (_____) _____-_____ Fax: (_____) _____-_____

Practice Name: _____ Practice Email: _____

Doctor Name: _____ Doctor Email: _____

Office Manager: _____ Manager Email: _____

Preferred Contact Method (check all that apply): ☐ Phone ☐ Fax ☐ Doctor Email ☐ Manager Email

Doctor Signature: _____ License #: _____

Contacts: ☐ Light ☐ Medium/Broad ☐ Heavy ☐ Point ☐ Other (specify below)

Metal Design: ☐ Collarless ☐ Lingual Collar Only ☐ 360° Collar ☐ Point ☐ Other (specify below)

Staining: ☐ Light ☐ Medium ☐ Heavy ☐ None

Occlusal Anatomy: ☐ Primary ☐ Secondary ☐ Match Adjacent ☐ Other (specify below)

Occlusal Clearance:: ☐ Light ☐ Full/In Occlusion ☐ Out of Occlusion ☐ 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 any additional instructions or preferences: _____