

ORDER FORM



บริษัท เอฟ.ดับบลิว.เด็นโทเจเนซิส จำกัด

F.W. Dentogenesis Limited

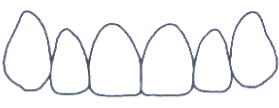












10/19 Moo 3 Soi Mahanakorn,
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OUR REF NO. _____

RETURN DATE _____

TIME _____


PATIENT NAME _____ _____ SEX _____ AGE _____	<p align="center">PORCELAIN FUSED TO METAL</p> <p align="center"><i>Alloy Type</i></p> <input type="checkbox"/> NON-PRECIOUS <input type="checkbox"/> WHITE HIGH NOBLE <input type="checkbox"/> NOBLE (2% Pd) <input type="checkbox"/> YELLOW HIGH NOBLE	<p align="center">BUCCAL MARGIN DESIGN</p> <input type="checkbox"/> METAL HAIRLINE ORMM. ON BUCCAL <input type="checkbox"/> METAL - PORCELAIN JUNCTION MARGIN <input type="checkbox"/> PORCELAIN BUTT MARGIN.....
<p align="center">COLOR</p>  <p> <input type="radio"/> CHROMASCOP <input type="radio"/> VITA <input type="radio"/> OTHERS SHADE : </p>	<p align="center">FULL CAST RESTORATIONS</p> <input type="checkbox"/> FCC <input type="checkbox"/> NON-PRECIOUS <input type="checkbox"/> INLAY/ONLAY <input type="checkbox"/> NOBLE <input type="checkbox"/> POST & CORE <input type="checkbox"/> YELLOW HIGH NOBLE	<input type="checkbox"/>  COPING WITH FULL PORCELAIN COVERAGE <input type="checkbox"/>  METAL COPING WITH PORCELAIN COVERAGE <input type="checkbox"/>  METAL OCCLUSAL EXCLUDING BUCCAL CUSP <input type="checkbox"/>  METAL OCCLUSAL INCLUDING BUCCAL CUSP
	<p align="center">COPOSITES BONDED TO METAL</p> <p align="center"><i>Composite Type</i> <i>Alloy Type</i></p> <input type="checkbox"/> BELLE-GLASS HP <input type="checkbox"/> NON-PRECIOUS <input type="checkbox"/> <input type="checkbox"/> YELLOW HIGH NOBLE	<p align="center">ANTERIOR DESIGN / LINGUAL</p> <input type="checkbox"/>  FULL PORCELAIN <input type="checkbox"/>  1/4 METAL <input type="checkbox"/>  3/4 METAL
<p align="center">OCCLUSAL STAINING</p> <input type="checkbox"/> NONE <input type="checkbox"/> LIGHT <input type="checkbox"/> MEDIUM <input type="checkbox"/> DARK	<p align="center">ALL CERAMICS</p> <input type="checkbox"/> E.MAX PRESS <input type="checkbox"/> PROCERA ALLCERAM <input type="checkbox"/> CERCON <input type="checkbox"/> PROCERA ALLZIRKON	<p align="center">PONTIC DESIGN</p> <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 
<p align="center">SPECIFIC INSTRUCTIONS</p> <input type="checkbox"/> METAL TRY-IN <input type="checkbox"/> LAB REMAKE <input type="checkbox"/> ENCLOSED STUDY MODEL FOR <input type="checkbox"/> FORM AND LENGTH <input type="checkbox"/> FIT CROWN TO EXISTING PARTIAL	<p align="center">FIBER RENFORCED COMPOSITES</p> <input type="checkbox"/> BELLE-GLASS HP	<p align="center">DENTURES</p> <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> TRY-IN <input type="checkbox"/> FINISH <input type="checkbox"/> CUSTOM TRAY <input type="checkbox"/> OCCLUSION RIM <input type="checkbox"/> BLEACHING TRAY <input type="checkbox"/> NIGH GUARD (Soft, hard) SHADE.....MOULD.....

CO-CR PARTIAL FRAME


 WIRONIT WIRONIUM GOLD
 FRAME TRY-IN
 FRAME WITH OCCLUSION RIM
 FRAME WITH TEETH TRY-IN
 FINISH
 ATTACHMENT

DESIGN

<p align="center">MAJOR CONNECTOR</p> <input type="checkbox"/> MAXILLARY <input type="checkbox"/> MANDIBULAR <input type="checkbox"/> PALATAL STRAP <input type="checkbox"/> LINGUAL BAR <input type="checkbox"/> HORSESHOE <input type="checkbox"/> LINGUAL APRON <input type="checkbox"/> DOUBLE PALATAL BAR <input type="checkbox"/> DOUBLE BAR	<p align="center">DIRECT RETAINERS</p> <input type="checkbox"/> SUPRABULGE _____ <input type="checkbox"/> INFRABULGE _____ <input type="checkbox"/> ESTHETIC _____ <input type="checkbox"/> W.W. _____	<p align="center">TOOTH #</p> _____ _____ _____
<p align="center">SADDLE AREAS</p> <input type="checkbox"/> MESH _____ <input type="checkbox"/> MESH WITH POSTS _____ <input type="checkbox"/> METAL PADS WITH POSTS _____ <input type="checkbox"/> OPEN-FACE PONTIC _____	<p align="center">REST AREAS</p> <input type="checkbox"/> MESIAL REST _____ <input type="checkbox"/> DISTAL REST _____ <input type="checkbox"/> CINGULUM REST _____	<p align="center">TOOTH #</p> _____ _____ _____



UPPER



LOWER

INSTRUCTIONS :r

DENTIST NAME : _____ SINGNATURE : _____ LICENSE NO. : _____

CLINIC : _____ DATE : _____