Aesthetic Aim

DENTAL LAB

"Art & Science Defined"

# Straumann coDiagnostiX Prescription Form

*Date:___________* *DATE WANTED:_________*

*Doctor:___________________* *Patient:_________________*

*Requested Service(s)*

*_____Radiographic Stent* *____ Case Design with coDiagnostix (tentative case design only)*

*____DICOM File Conversion* *____ Surgical Guide from EZ Bite* *____Temporizations (shade)*

*____ Surgical Guide from Radiographic Stent (From approved plan only)*

| Implant Type (Preference) | Implant Size (Preference) | Implant Site | Flap | Flapless |
|---|---|---|---|---|
| ________________ | _________________ | ______ | ____ | ____ |
| ________________ | _________________ | ______ | ____ | ____ |
| ________________ | _________________ | ______ | ____ | ____ |
| ________________ | _________________ | ______ | ____ | ____ |

*Planning Communications: (please check how you would like plan sent)*

*ipad_______ Phone call_______ text message_______ email_______Set up office visit_______*

*Web_______*

*Additional Comments:*

*DOCTOR'S SIGNATURE:_________________________________ LIC#.___________*

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