



HELM DENTAL
LABORATORY



DIGITAL ESTHETIC
SOLUTIONS

Locator Fixed RX

www.helmdentallaboratory.com | info@helmdentallaboratory.com

Main Laboratory: 2801 Capital St. Wylie, TX 75098 | 972-442-9772

Date: _____

Doctor Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Email: _____

Phone: _____

Patient Name: _____

Sex: Male Female Age: _____

CASE INFORMATION

ARCH SELECTION *(Please use separate RX for each arch)*

- Maxilla
 Mandible

AESTHETIC INFORMATION

TOOTH SET-UP *(select one)*

- Match existing teeth
 Mould & Shape
 Lab to select teeth (default)

LIP SUPPORT *(select one)*

- Decrease _____ mm
 Increase _____ mm
 Leave lip support as is (default)

TISSUE SHADE *(select one)*

- Original (Pink) (default) Light Reddish Pink (Medium)
 Light Pink (Light) Dark Reddish Pink (Dark)

LOCATOR FIXED PACKAGES *(per arch)*

- Option #1: Framework/PMMA
 Option #2: Framework/Printed Denture Base with Milled Teeth
 Option #3: Framework/Zirconia
 Locator Fixed Processing Kits (each)

Quantity: _____

TYPE OF IMPRESSION

- Scan / Digital

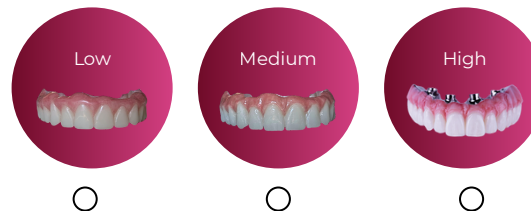
NEXT APPOINTMENT *(select one)*

- Optional:** Printed try-in, monotone color (no charge but requires an additional appointment)
 Process & finish for final denture

INCISAL SHOW / REVEAL *(select one)*

- Decrease _____ mm
 Increase _____ mm
 Leave incisal show / reveal as is (default)

CHARACTERIZATION ZIRCONIA *(select one)*



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LOCATOR FIXED PRICING *(per arch), includes:*

- Digitization of models
- Choice of tooth type (printed, milled, individual, combo as outlines in pricing above)
- Optional printed try-in, monotone color
- Custom designed & printed final denture with patient ID

Please **PRINT** ALL information. Complete all sections that apply to this case & patient's **next** appointment. Keep a copy for your files. We will call you before proceeding if we have any questions.

If no choice is indicated, lab defaults, as indicated will be used.

RECORDS *(Please check all that apply & enter info to right)*

- Final Shade _____
 Photos (date sent to lab) _____
 Cant corrections _____
 Occlusal plane corrections _____
 Planned changes in VDO _____

ADDITIONAL INSTRUCTIONS: *(Please print legibly)*



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Doctor's Signature _____

License No. _____

The person signing this authorization and/or the dental practice accepts responsibility for payment of the related charges & agrees to pay all legal & collection costs in the event the account is in collections or litigation, including reasonable fees.