



# Palmer Dental Ceramics

1123-A Babcock  
San Antonio, Texas 78201

(210) 733-3215  
Texas State Registration #01512

Patient Name (Printed) _____		Due Date _____	
Age _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Shade No. _____
<input type="checkbox"/> Metal coping all porcelain coverage <input type="checkbox"/> Metal occlusal excluding buccal cusp <input type="checkbox"/> Metal occlusal including buccal cusp		 Please indicate characterizations desired <b>PONTICS</b> 	
Lingual <input type="checkbox"/> 3/4 Metal <input type="checkbox"/> 1/4 Metal <input type="checkbox"/> Metal Band		Buccal Margins: <input type="checkbox"/> Porcelain Shoulder <input type="checkbox"/> Porcelain/Metal <input type="checkbox"/> Metal Band Opposing Teeth to be Restored: <input type="checkbox"/> Yes <input type="checkbox"/> No Occlusal Staining: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy Metal: <input type="checkbox"/> High Noble <input type="checkbox"/> Noble <input type="checkbox"/> Base <div style="text-align: right; padding-right: 20px;"> <input type="checkbox"/> Metal Try-In  <input type="checkbox"/> Finish         </div>	
<b>CONTACTS:</b> <input type="checkbox"/> Broad <input type="checkbox"/> Narrow <input type="checkbox"/> Medium <input type="checkbox"/> Tight <input type="checkbox"/> Light			
<b>Rx</b> <span style="margin-left: 200px;">FOLD HERE</span>			
Dr's Name (Printed) _____		Doctor's Signature _____	
D.D.S. License #: _____		Date: _____	