PLEASE DO NOT COUNT SATURDAYS, SUNDAYS, HOLIDAYS, OR DAYS IN TRANSIT AS WORKDAYS

SURGERY DATE _____

TIME _____

IMPLANT SOLUTIONS, LLC USE ONLY

PAN # _____

PLEASE COMPLETE SECTIONS 1 - 4.

1

PATIENT NAME _____

DOCTOR _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____ FAX _____

E-MAIL _____

2

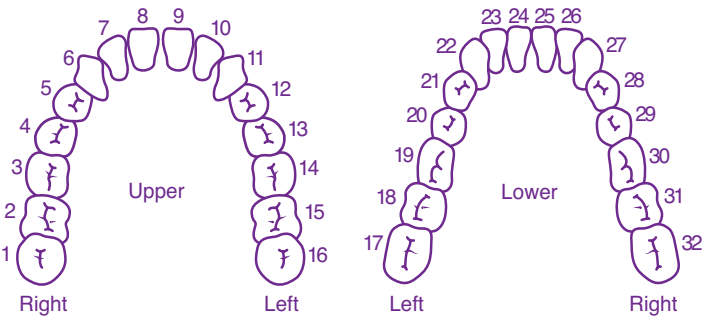
INFORMATION NEEDED FOR PLANNING:

Implant Manufacturer _____

PLANNED RESTORATION:

☐ Crown & Bridge ☐ Removable Overdenture ☐ Fixed Overdenture

3



4

FABRICATE:

☐ Conventional Scanning Appliance ☐ Custom Tissue Former ☐ Temporary Crown

☐ Treatment Plan Proposal ☐ Custom Abutment ☐ Temporary Denture

☐ Surgical Drilling Appliance ☐ Flipper ☐ Essex Retainer

Notes: _____

☐ I hereby grant Implant Solutions, LLC permission to make minor changes to my plan as necessary.
Please return the appliance and disk to Implant Solutions, LLC

SIGNATURE: _____ LICENSE NO: _____

IMPLANT SOLUTIONS, LLC
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