GALAXY
Dental Studio

REQUIRED INFORMATION

Doctor Name _____
Last First

Practice Name _____

Address _____

Phone _____

Patient Name _____

Patient Chart # _____ ☐ M ☐ F DOB _____

Rx Date _____ Due Date/Delivery on _____
(standard working time if no date given)

☐ **IMPLANT SYSTEM :** ☐ **SIZE**

CASE INSTRUCTIONS

Please CIRCLE single units and BRACKET splinted units

1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17

zirconia

☐ *GALAXY ESTHSTC CROWN*
(Porcelain Layered Zirconia Crown)

☐ *GALAXY ST CROWN*
(Super Translucent Full Contour zirconia)

☐ GALAXY ZIRC CROWN
(MULITI LAYERD Full Contour zirconia)

Emax

☐ E.max®ESTHETICS /Lisi
Press VENEER & Crown

☐ E.max®ESTHETICS/Lisi
NATURAL VENEER & Crown
PORCELAIN LAYERED veneer & crown

implant

☐ GALAXY Implant Crown
(MULTI LAYERD Full Contour zirconia)

☐ GALAXY ST IMPLANT CROWN
(Super Translucent Full Contour zirconia)

☐ GALAXY Natural Implant Crown
(Porcelain Layered Zirconia Crown)

☐ GALAXY All on X

ESTHETICS REQUIREMENT

☐ Translucent
☐ Textures

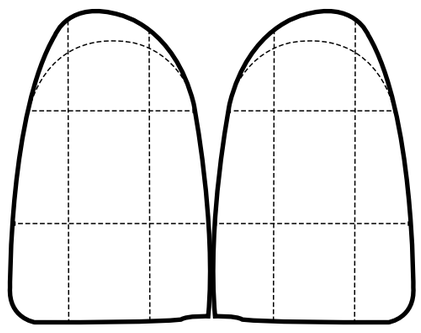
☐ Soft Night Guard

☐ Doullaminate night Gurad

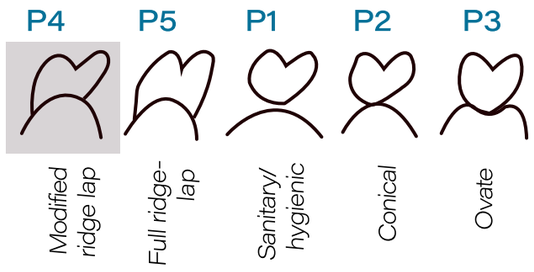
☐ Thermoplastic printed night guard

CROWN DESIGN

Characterizations



Pontic Design



Tooth Shade _____ Shade Guide Used _____
(REQUIRED) (vita is default)

Stump Shade _____ Pink Tissue Shade _____
(REQUIRED FOR E. MAX)

Occlusal Contact	Interproximal Contact
☐ Light*	☐ Light*
☐ Open	☐ Medium
☐ Tight	☐ Heavy

NOTICE;

Please provide any photos, study models, diagnostic casts with cas
Email photos to: PHOTO@galaxydentalstudio.ca
Mississauga,ON

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