

FIRST FIT®

Powered by  HENRY SCHEIN®

Account Number _____
 Doctor Name _____
 License Number _____
 Zip Code _____
 Telephone Number _____
 Email _____
 Certification Number _____

Date _____
 Patient Name _____
 Age _____ Sex _____
 Due Date _____
 Patient Appointment _____ Time _____
 Try-In Date _____ Time _____

ENCLOSURES

We recommend to include study models and photos of the cases that involve anterior teeth.

- Impressions (Full arch—upper and lower) Bite registration Photos
 Stump Shade Shade request Diagnostic wax-up

Are there existing restorations within the FirstFit treatment area Yes No

If yes, please specify _____

PHOTO PROTOCOL

- FirstFit veneers photo protocol
 Intraoral scan

Others: _____

MATERIAL

- e.max Lithium Disilicate

TOOTH NUMBERS

FINISHING

- Monochrome Stain and glaze Polish

Color natural teeth: _____

Color ceramic restorations: _____

DESIGN SPECS

- Youthful Natural Mature

Indicate: _____

SHADE SPECS

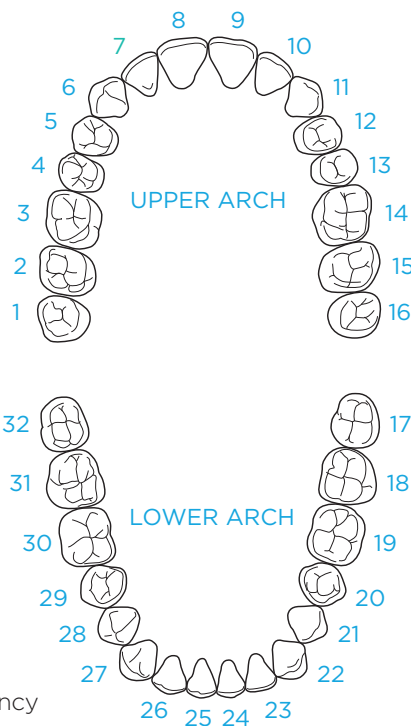
- Monochromatic Polychromatic Incisal Translucency

PRIMARY OBJECTIVE

- Chips/Cracks Misalignment Discoloration Stump Shade Diastemas

CASE DESIGN

- Alignment Recontouring Length: _____



LAB USE ONLY

IMPRESSION VERIFICATION

Approved on: _____

Rejected on: _____

Called on: _____

By: _____

DENTIST CONSULTATION YES NO

Held on: _____

By: _____

Called on: _____

By: _____

- Approval of digital teeth preparation.

- Approval of restoration design

Approved on: _____

UNIT VERIFICATION

By: _____

FINAL QC

By: _____