bicon®
DENTAL IMPLANTS

BIN# _____
☐ IMP ☐ FRM ☐ SHD ☐ BITE
☐ OPP ☐ ABT ☐ CRN ☐ ____
(For office use only)

DOCTOR CUST.# MM / DD / YY

ADDRESS

CITY STATE ZIP

PHONE EMAIL (Required)

PATIENT GENDER (Circle One) **M F**

Allow 15 Business Days After Receipt

☐☐ ☐☐ ☐☐
M M D D Y Y

REQUIRED:

- **Full arch impressions**
- **No triple trays accepted**
- **Bite registration with rigid material**

Digital photos strongly recommended for optimal shade results. rx@bicon.com

VITA CLASSIC SHADE

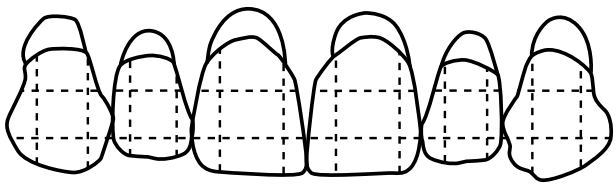
Circle one.

A1 A2 A3 A3.5 A4
B1 B2 B3 B4
C1 C2 C3 C4
D2 D3 D4
Other _____

Stain? ☐ YES ☐ NO

INDIVIDUAL / BRIDGE

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



RESTORATION

Rx

IF HEALING ABUTMENTS WERE USED, INDICATE DIAMETER

Tooth # Diameter

_____ _____

_____ _____

Fixed

☐ Integrated Abutment Crown™
☐ Polyceramic Crown
☐ CAD/CAM Restorations – Indicate Choice:
Full Contour Crown ☐ e.Max™ ☐ Zirconia ☐ Shofu Block
Layered Crown ☐ e.Max™ ☐ Zirconia
☐ PFM » Alloy: ☐ NP ☐ N ☐ HN

TRINIA™

☐ Bar With Telescopic Coping or ☐ Without Telescopic Coping
☐ Candulor™ Teeth or ☐ Ceramage™ Build-Up
☐ Framework
Bridge work must be tried prior to finish.

Removable Overdenture

☐ Brevis™ or ☐ Locator®

Other

Explain:

PAYMENT: ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS ☐ COD

CARD NUMBER EXPIRES SECURITY CODE

SIGNATURE (Required) LICENSE NUMBER

Each Rx Slip constitutes a complete and separate transaction to be invoiced and paid as such.
By signing I understand and accept the warranty terms and conditions of Bicon Digital Prosthetics. See Bicon Digital Prosthetics invoice for warranty, terms, and conditions.

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