

PFM - CROWNS

- Type** **Mil Type** (HN) YELLOW GOLD (Au 88%)
 CERA-PLUS™ (HN) WHITE GOLD (Au 51%)
 CERA-TECH™ (economy) (HN) WHITE GOLD (Au 40%)
 IMPLANT (N) Noble (Au 2%, Pd 81%)
 (NP) Non-Precious (CrCo)

ALL-CERAMIC

- Type** Crown/Onlay Inlay Veneer
 CERA-MAX™ (Full Contour Zirconia Crown) BRUXZIR®
 E.MAX® (Full Contour) E.MAX® (Layered Incisal)
 PORCELAIN FUSED to ZIRCONIA Crown (PFZ)
 REFRACTORY

CAST GOLD

- Type** **Metal Type (HN)**
 CROWN / ONLAY YELLOW GOLD (Au 74%)
 INLAY YELLOW INLAY GOLD (Au 77%)
 ECONOMY GOLD (Au 55%)

Gold Occlusal Polish Instructions

- HIGH SHINE Occl. SATIN FINISH Occl. (Glass Beaded)

POLYMER & CERAMIC POLYMER


- Type** Crown/Onlay Inlay Veneer
 SINFONY Long-term Provisionals
 LAVA™ ULTIMATE PMMA Acrylic Temp (HS)
 VITA ENAMIC™ INSTA-TEMP® MAX

DIAGNOSTIC WAX

- DIAGNOSTIC WAX-UP > White wax Beige wax
 SPLIT PUTTY MATRIX PREP GUIDE VACUUM FORM STENT
 PUTTY/WASH MATRIX MOLD for creat'g detailed provisionals

OCCUSAL STAINING

- CHARACTERIZATION** **CHROMA** **VALUE**
 DELICATE/young LOW LOW NONE
 MEDIUM/mid-age MEDIUM MEDIUM LIGHT
 VIGOROUS/elderly HIGH HIGH MEDIUM
 HEAVY

 DIGITAL PHOTOS may be sent to: cdt@killiandental.com
 (Please include doctor & patient name in email subject line.)
 Also, we accept Clearmatch and X-rite images.



 PLEASE SEND PREOP AND POSTOP STUDY MODELS
 for all work involving anterior teeth.



Killian Dental Ceramics, Inc.
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 email: cdt@killiandental.com
 www.KillianDental.com

Killian DENTAL LABORATORY

DOCTOR _____

PATIENT _____ M F AGE _____
PLEASE PRINT

DATE PREPARED _____ APPOINTMENT DATE _____

DATE DUE - deliver by 5:00 p.m. on: _____

INSTRUCTIONS*

* Standard Options will be used, unless instructed otherwise.

FINISHED SHADE _____
(Crown, Restoration)

- METAL TRY-IN
 BISQUE TRY-IN
 FINISH

PREP STUMP COLOR _____
(Prep Stump Color is required for all-ceramic restorations, because the underlying preparation color affects the final shade of all-ceramic restorations.)



Please indicate future restorations

By signing below, you acknowledge that this order, including the terms on its reverse side, represents the full and complete agreement between you and Killian Dental Ceramics, Inc. with respect to the products ordered herein.

DR. SIGNATURE (required) _____ DR. LIC# _____ DATE _____

SEE CHECKLIST ON BACK SIDE

 PRIOR TO IMPRESSIONING
please polish rough proximal contacts.

PROXIMAL CONTACTS

- LIGHT
 MEDIUM
 HEAVY-SCRAPE CAST

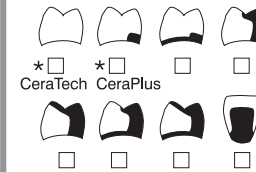
OCCUSAL CONTACTS

- LIGHT - 0.3 mm SUB
 MEDIUM 0.1 mm SUB
 HEAVY - Touching opposing

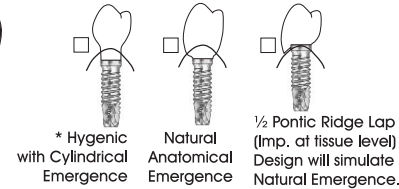
IF NO OCCUSAL CLEARANCE

- METAL OCCUSAL REDUCTION COPING YES NO
 Is this preference for all your cases?
 ADJUST OPPOSING
 CALL ME (Do not proceed until we talk)

METAL DESIGN



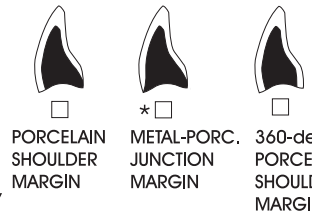
ABUT. & RESTOR. CONTOUR



TEXTURE

- * HIGH GLAZE
 NATURAL GLAZE
 COPY NATURAL TEETH

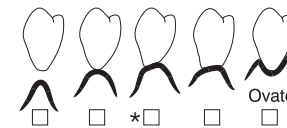
MARGIN DESIGN



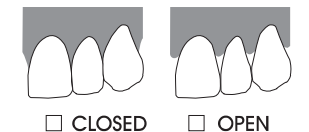
CONTOUR

- * IDEAL
 ROTATED
 OVERLAPPED
 CROSS-ARCH SYMMETRY

PONTICS



GINGIVAL EMBRASURES



EDENTULOUS RIDGE SCRAPE CAST

- NONE
 LIGHT 0.2 mm
 MEDIUM 0.5 mm
 HEAVY (Extraction) _____ mm

OCCUSAL TABLE BUCCAL-LINGUAL WIDTH

- * NORMAL - Natural
 NARROW - 3/4 width