

New Zealand Laboratory Order Form



Doctor: _____ Cust. Ref: _____

Practice Name: _____ Tel: _____

Address: _____ Return Date: _____ Time: _____ AM / PM

PATIENT INFORMATION Name: _____ Age: _____ ☐ Male ☐ Female

RACE DENTAL NZBN 9429041636015
20-24 Crummer Road
Grey Lynn, 1021 Auckland
T: (09) 887 0327 | www.racedental.co.nz
E: customersupport@racedental.co.nz

CROWN / BRIDGE / IMPLANTS

RESTORATION TYPE <input type="checkbox"/> Crown <input type="checkbox"/> Bridge <input type="checkbox"/> Inlay / Onlay <input type="checkbox"/> Veneer <input type="checkbox"/> Implant Screw Retained <input type="checkbox"/> Implant Cement Retained Implant Brand _____ <input type="checkbox"/> Other _____	MATERIAL TYPE Metal-Free <input type="checkbox"/> Opalite™ (Translucent Zirconia) <input type="checkbox"/> Crystalite (Super Translucent Zirconia) <input type="checkbox"/> Zirconia Layered <input type="checkbox"/> IPS e.max® CAD <input type="checkbox"/> IPS e.max® Pressed <input type="checkbox"/> VITA® Enamic <input type="checkbox"/> 3M ESPE Lava™ Plus (Translucent Zirconia)	PFM/FGC <input type="checkbox"/> Premium PFM: <input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi-Precious <input type="checkbox"/> Precious (Yellow Gold) <input type="checkbox"/> Standard PFM: <input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi-Precious <input type="checkbox"/> Precious (Yellow Gold) <input type="checkbox"/> Full Gold Crown: <input type="checkbox"/> Non-Precious (CoCr) <input type="checkbox"/> Non-Precious (Gold) <input type="checkbox"/> Precious (Yellow Gold)	OCCLUSAL STAINING <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Dark POST & CORE <input type="checkbox"/> Post & Core (Only) <input type="checkbox"/> Post & Crown (Separate) <input type="checkbox"/> Post & Crown (One Piece) <input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi Precious <input type="checkbox"/> Precious (Yellow Gold)	Basic Shade: Stamp Shade: Tooth Number(s):
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EMBRASURE
☐ Natural ☐ Closed ☐ Open
Occlusal Contact
☐ Heavy ☐ Light ☐ Open
Proximal Contact
☐ Normal ☐ Broad
Pontic Design
☐ Ovate ☐ Ridge Lap ☐ Hygienic

SPECIAL INSTRUCTIONS

COPING TYPE
☐ Regular Coping
☐ Full 360° Porcelain Margin
☐ Full 360° Metal Margin
☐ Half Metal Occlusal
☐ Full Metal Occlusal

IF INSUFFICIENT ROOM:
☐ Reduce prep & mark model
☐ Reduce opposing & mark model
☐ Reduce prep, make reduction key
☐ Send back for re-prep

☐ Turn Over For Additional Instructions



Email photos with Dr and Patient name in the subject line to:
images@racedental.co.nz

Photos Sent ☐

ORTHODONTICS Due Date _____

RETAINER <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Hawley <input type="checkbox"/> Begg <input type="checkbox"/> Trutain <input type="checkbox"/> Spring Hawley <input type="checkbox"/> Spring Aligner <input type="checkbox"/> Lingual Arch 3x3 <input type="checkbox"/> Other _____	OCCLUSAL SPLINTS <input type="checkbox"/> Heat Cured <input type="checkbox"/> Hard / Soft <input type="checkbox"/> Hard / Soft with Acrylic <input type="checkbox"/> Soft <input type="checkbox"/> Anterior Mini Splint <input type="checkbox"/> Gelb <input type="checkbox"/> Other _____	REMOVABLE <input type="checkbox"/> Schwartz <input type="checkbox"/> Sagittal / Schwartz <input type="checkbox"/> 3D <input type="checkbox"/> Twin Block <input type="checkbox"/> Bionator <input type="checkbox"/> Other _____	FIXED <input type="checkbox"/> Herbst <input type="checkbox"/> RME (Banded) <input type="checkbox"/> RME (Acrylic) <input type="checkbox"/> Superscrew <input type="checkbox"/> Quad Helix <input type="checkbox"/> Lingual Arch 6x6 <input type="checkbox"/> Space Maintainer <input type="checkbox"/> Other _____
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MISCELLANEOUS
☐ Bleaching Tray
☐ Snoring Device
☐ Race Mouthguard (Single Layer)
☐ Fortress Mouthguard Light
☐ Fortress Mouthguard Medium
☐ Fortress Mouthguard Heavy
Colour _____
☐ Other _____

ACRYLIC / CHROME

CHROME CASTING <input type="checkbox"/> P/- <input type="checkbox"/> -/P <input type="checkbox"/> Special Tray <input type="checkbox"/> Frame Only <input type="checkbox"/> With Wax Bite <input type="checkbox"/> Separate Wax Bite <input type="checkbox"/> With Try-in <input type="checkbox"/> Separate Try-in <input type="checkbox"/> Finish <input type="checkbox"/> Titanium Casting <input type="checkbox"/> Backings / Onlays Teeth numbers: _____ <input type="checkbox"/> Other _____	ACRYLIC DENTURE <input type="checkbox"/> FLEXIBLE DENTURE <input type="checkbox"/> <input type="checkbox"/> F/- <input type="checkbox"/> -/F <input type="checkbox"/> P/- <input type="checkbox"/> -/P <input type="checkbox"/> Special Tray <input type="checkbox"/> Wax Bite <input type="checkbox"/> Try-in <input type="checkbox"/> Finish <input type="checkbox"/> Other _____ CLASPS <input type="checkbox"/> Stainless Steel Clasps Teeth numbers: _____ <input type="checkbox"/> Tooth-Coloured Clasps Teeth numbers: _____ <input type="checkbox"/> Clear Clasps Teeth numbers: _____ <input type="checkbox"/> Pink Clasps (Flexible) Teeth numbers: _____	REPAIRS <input type="checkbox"/> F/- <input type="checkbox"/> -/F <input type="checkbox"/> P/- <input type="checkbox"/> -/P <input type="checkbox"/> Fracture <input type="checkbox"/> Addition Tooth number: _____ <input type="checkbox"/> Imm Exo Addition Tooth number: _____ <input type="checkbox"/> Clasp (Addition) Tooth number: _____ <input type="checkbox"/> Strengthen <input type="checkbox"/> Other _____	
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DENTURE SHADE:

SPECIAL INSTRUCTIONS

PATIENT APPOINTMENTS

Date 1 _____ Time: _____ am/pm	Date 4 _____ Time: _____ am/pm
Date 2 _____ Time: _____ am/pm	Date 5 _____ Time: _____ am/pm
Date 3 _____ Time: _____ am/pm	Date 6 _____ Time: _____ am/pm

☐ Turn Over For Additional Instructions

[illegible]

Date received: _____

impression	model	bite	tray	job box number
articulator	teeth	wax try-in	c/c	
key	wax up	articulator box		
crown	splint	denture	veneer	
implant h/w		broken model		
CD	photo	die		