



CASE INFORMATION

Doctor: _____

Patient Name: _____

Date Sent: _____

Date Due in Office: _____

Implant Brand / Type: _____

MUA Used Y / N MUA Brand: _____

Tooth Shade _____ Mold _____ Tissue Shade _____

Upper ☐ G5 ☐ G4 ☐ Prime Z ☐ MZ ☐ Denture

Lower ☐ G5 ☐ G4 ☐ Prime Z ☐ MZ ☐ Denture

G5 - PMMA w/Chrome, Milled Interface Prime Z = Zirconia w/Substructure
G4 - PMMA w/Chrome, TiBases MZ - Monolithic Zirconia

1. INITIAL RECORDS – Determining Tooth Setup

DENTATE START – Create Setup ☐ U ☐ L

EDENTULOUS START OPTIONS

- ☐ Full Setup Tryin ☐ U ☐ L
- ☐ Anterior/Partial Setup Tryin ☐ U ☐ L
- ☐ Trial Base / Bite Rims ☐ U ☐ L
- ☐ Provide File for In-Office Printing
Email: _____

2. SURGICAL GUIDE OPTIONS

- Surgery Date _____
- Guided Drill System _____
- ☐ Pre-Surgical Planning Only ☐ U ☐ L
- ☐ **Dentate** eXact Fully Guided ☐ U ☐ L
- ☐ **Edentulous** eXact Fully Guided ☐ U ☐ L
- ☐ Mucosa-Supported Guide ☐ U ☐ L
- ☐ Non-Restrictive Denture Guide (3in1) ☐ U ☐ L

3. PROVISIONAL OPTIONS – Choose One

- ☐ Immediate Fixed Provisional ☐ U ☐ L
Only available with eXact Guides
- ☐ Backup Printed Denture ☐ U ☐ L
- ☐ Use Non-Restrictive Guide (3-in-1) ☐ U ☐ L
- ☐ Temporary Denture ☐ U ☐ L
- ☐ Provisional Design Only ☐ 1 Hour ☐ Next Day

4. POST-IMPLANT CAPTURE

☐ **Photogrammetry Capture**

Camera Brand: _____

☐ STL sent ☐ Coordinates sent (.csv file)

☐ **IOS Scanalog™** * Intra-oral cementation recommended

☐ **IOS Alternative** System
Optisplint, IOConnect, etc Used: _____

Scanbody Chosen: _____

☐ **XD CBCT** * Intra-oral cementation required
CBCT Dual Scan

Required Implant Information: **Diameter/Length** of each individual implant w/ associated **cuff height** for MUA's if used. Please notate on page 2 of the rx.

☐ **Analog Index/Impression**

5. POST-IMPLANT TRYIN (Optional)

☐ Modification needed ☐ Remount

☐ **Screw Retained Printed Tryin** ☐ U ☐ L

☐ Provide File for In-Office Printing
Email: _____

☐ **Long Term Fixed Provisional** ☐ U ☐ L
(PMMA Prototype)

☐ **Hybridge Framework with Setup** ☐ U ☐ L

6. PROCESS / FINISH – Choose Final Product

Upper ☐ G5 ☐ G4 ☐ Prime Z ☐ MZ ☐ Denture

Lower ☐ G5 ☐ G4 ☐ Prime Z ☐ MZ ☐ Denture

☐ Modification needed ☐ Remount ☐ MZ Upgrade to Gingival Layering ☐ Cement Ti-Bases Chairsides

☐ Duplicate Hybridge ☐ Retread Existing Hybridge ☐ Reline

EXOCAD Review ☐ Dr. Name _____

SPECIAL INSTRUCTIONS:

☐ Smile Design Sent

Prosthetic Vision Checklist

Vertical Dimension

☐ Approved

Open _____

Close _____

If changes, at the expense of
Upper / Lower / Both

Horizontal Overjet

☐ OK

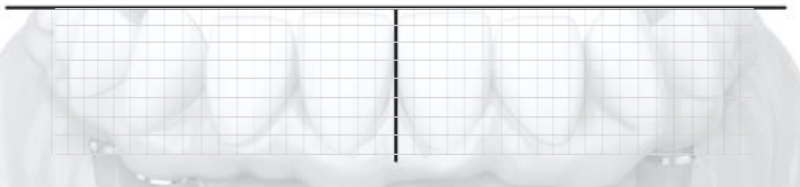
Change _____

Arch Form

☐ OK

☐ Widen ☐ Pull In

Desired Gingival Height / Incisal Length / Midline



Notes