

Implant Bar Prescription

Company / Lab Name _____ Date _____

Contact Name _____ Email _____ Phone _____

Patient Name _____ Digital File Name _____

Case Due Date _____ Digital Approval Required Yes No

MUST INCLUDE WITH CASE

VERIFIED MODEL **Do not include articulator or opposing model.**

WAX TRY-IN **All analogs must be undamaged**

SOFT TISSUE

OVERDENTURE

HADER **Height:** _____

MILLED BAR **Height:** _____

Width: _____

FIXED HYBRID BARS

WRAP AROUND BAR
Amount of space _____

LOCATOR BAR
Amount of space _____

TITANIUM IN CONTACT WITH TISSUE (LOW LINGUAL)
Amount of space _____

TITANIUM NOT IN CONTACT WITH TISSUE (HIGH LINGUAL)
Amount of space _____

Implant Type	Implant Ref	Tooth No.
<input type="checkbox"/> ASTRA	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> BIOHORIZONS	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> BIOMET3I	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> NOBEL	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> STRAUMANN	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> ZIMMER	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> OTHER	<input type="text"/>	<input type="text"/>

Scan / Design

IMPLANT BAR SCAN ONLY IMPLANT BAR SCAN & DESIGN



O Mark Implant Position **X** Mark Attachment

Notes