BE GUIDED

Ordering Doctor: _____ Phone : _____

Address:_____City/State/Zip_____

Patient Name: _____ Due Date: _____Surgery Date:_____

Surgeon (If Different):_____

Surgical Guide

Required

CBCT (DICOM File) _____

Casts_____

Intraoral Scan (please contact for more info)_____

Implant Sites #'s_____

Implant Manufacturer and Type_____

Pilot Guide Only or Fully Guided_____

Flapped or Mucosal Punch_____

Date and Time Doctor can Schedule 10 Minute Online Case Review_____

(guide will be delivered within 5 business days of implant placement confirmation)

Opposing Cast (only necessary if requesting virtual teeth)

Please indicate if you would like virtual tooth or Diagnostic wax up for teeth #_____

Instructions:

_____

_____

Dentist License Number:_____

Dr's Signature_____

*** We are not responsible for fit of stent intraorally on all STL files sent digitally.**