

LABORATORY CHECKLIST

mf M. FRADEANI

gb G. BARDUCCI

Patient _____ Age _____ Date ____ / ____ / ____ Male Female

ESTHETIC INFORMATION






PATIENT'S PHOTOGRAPH



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PHOTOGRAPHS Old New **SMILE LINE** Average Low High
 ALIGNMENT Yes No **APPEARANCE** Youth Adult Mature
 TOOTH TYPE  Ovoid  Triangular  Square
 TEXTURE **Macro** None Slight Pronounced **Micro** None Slight Pronounced

OCCLUSAL PLANE vs COMMISSURAL LINE - HORIZON


Parallel Slanted right Slanted left
 Maintain Modify Maintain Modify

Indicate modifications: Mark with + to lengthen and - to shorten

(mm) 16	15	14	13	12	11	21	22	23	24	25	26	(mm)
(mm) 46	45	44	43	42	41	31	32	33	34	35	36	(mm)

Notes _____

COLOR



Shade Guide

Vita 3D Master


Ivoclar Other _____

Spectrophotometer



Yes No

Value



High Low




Notes _____

SHAPE	Modifications	POSITION
		
13 lengthen/shorten (mm)	widen/narrow (mm)	labial/palatal (mm)
12 lengthen/shorten (mm)	widen/narrow (mm)	labial/palatal (mm)
11 lengthen/shorten (mm)	widen/narrow (mm)	labial/palatal (mm)
21 lengthen/shorten (mm)	widen/narrow (mm)	labial/palatal (mm)
22 lengthen/shorten (mm)	widen/narrow (mm)	labial/palatal (mm)
23 lengthen/shorten (mm)	widen/narrow (mm)	labial/palatal (mm)

Notes _____

SHAPE	Modifications	POSITION
		
43 lengthen/shorten (mm)	widen/narrow (mm)	buccal/lingual (mm)
42 lengthen/shorten (mm)	widen/narrow (mm)	buccal/lingual (mm)
41 lengthen/shorten (mm)	widen/narrow (mm)	buccal/lingual (mm)
31 lengthen/shorten (mm)	widen/narrow (mm)	buccal/lingual (mm)
32 lengthen/shorten (mm)	widen/narrow (mm)	buccal/lingual (mm)
33 lengthen/shorten (mm)	widen/narrow (mm)	buccal/lingual (mm)

Notes _____

OVERJET	Modifications	OVERBITE
	<input type="checkbox"/> Confirmed <input type="checkbox"/> Decreased (mm) _____ <input type="checkbox"/> Augmented (mm) _____	<input type="checkbox"/> Confirmed <input type="checkbox"/> Decreased (mm) _____ <input type="checkbox"/> Augmented (mm) _____
Notes _____		

FUNCTIONAL INFORMATION

■ STONE CASTS

- | | | |
|---|---|--|
| <input type="checkbox"/> Previous
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular | <input type="checkbox"/> Diagnostic
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular | <input type="checkbox"/> Provisional
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular |
|---|---|--|

■ OCCLUSAL RECORDS

- MI CR Protrusive interocclusal record Lateral interocclusal records

■ VERTICAL DIMENSION

- | | | | | |
|------------------------------------|--|--|--|--|
| <input type="checkbox"/> Unchanged | <input type="checkbox"/> Increase (mm) _____ | <input type="checkbox"/> Maxillary (mm) _____ | <input type="checkbox"/> Decrease (mm) _____ | <input type="checkbox"/> Maxillary (mm) _____ |
| | | <input type="checkbox"/> Mandibular (mm) _____ | | <input type="checkbox"/> Mandibular (mm) _____ |

■ FACEBOW

- Arbitrary Kinematic Horizon Interpupillary Commissural Other _____

■ Reference lines

■ ARTICULATOR SET-UP

- | | |
|---|--|
| <input type="checkbox"/> Semi-adjustable | <input type="checkbox"/> Fully adjustable |
| <input type="checkbox"/> Condylar inclination (degrees) _____ | <input type="checkbox"/> Protrusive interocclusal record |
| <input type="checkbox"/> Progressive mandibular lateral translation (degrees) _____ | <input type="checkbox"/> Lateral interocclusal records |
| <input type="checkbox"/> Immediate mandibular lateral translation (mm) _____ | <input type="checkbox"/> Mechanical pantograph |
| | <input type="checkbox"/> Electronic pantograph |

■ DISOCCLUSION

- Incisal guidance Canine guidance Group function Balanced occlusion

IMPRESSION

Recorded on ____/____/____ Time ____:____ Disinfected with _____

■ Impression materials

- | | | |
|--|---|---|
| <input type="checkbox"/> ALGINATE
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular | <input type="checkbox"/> POLYETHER
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular | <input type="checkbox"/> ADDITION SILICONE
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular |
| <input type="checkbox"/> POLYSULFUR
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular | <input type="checkbox"/> CONDENSATION SILICONE
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular | <input type="checkbox"/> OTHER _____
<input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular |

DOCUMENTATION

■ CASE HISTORY

- | | |
|---|---|
| <input type="checkbox"/> Contagious diseases | <input type="checkbox"/> Psychomotor handicap |
| <input type="checkbox"/> Confirmed allergies | <input type="checkbox"/> Bruxism |
| <input type="checkbox"/> Other medical device present | <input type="checkbox"/> Other _____ |

Notes _____

■ ATTACHMENTS

- Slides/Photographs Esthetic Checklist Other _____

LABORATORY WORK ORDER

Dr name _____	Dental lab name _____
Address _____	Address _____
City _____ State _____	City _____ State _____
Telephone _____	Telephone _____

Date / / Work order no. _____

Patient/Code _____ Age _____ Male Female

TYPE OF WORK

- Diagnostic waxing
 Indirect mock-up
 Provisional
 Fixed prosthesis
 Removable prosthesis

Description _____

SCHEMA

o = Natural abutment □ = Implant X = Missing tooth

1	18	17	16	15	14	13	12	11		21	22	23	24	25	26	27	28	2
4	48	47	46	45	44	43	42	41		31	32	33	34	35	36	37	38	3

- | | | | |
|--------------------------------------|-----------------------------|-----------------------------------|--------------------------|
| PFM: Porcelain-fused-to-metal | PS1: Presoldering | PS2: Postsoldering | MM: Metal margins |
| MCM: Metal-ceramic margin | CS: Ceramic shoulder | PC: Post and core | ABU: Abutment |
| AC: All-ceramic | RB: Resin-bonded | V: Veneer IN: Inlay | ON: Onlay |

Alloy: _____

Ceramic: _____

COLOR



Shade Guide

Vitapan

3D Master

Ivoclar

Other _____

Value

High Low



TRY-INS

Try-in _____	Date <u> </u> / <u> </u> / <u> </u>	Notes: _____	<input type="checkbox"/> Attachment No. _____
Try-in _____	Date <u> </u> / <u> </u> / <u> </u>	Notes: _____	<input type="checkbox"/> Attachment No. _____
Try-in _____	Date <u> </u> / <u> </u> / <u> </u>	Notes: _____	<input type="checkbox"/> Attachment No. _____
Delivery _____	Date <u> </u> / <u> </u> / <u> </u>	Notes: _____	<input type="checkbox"/> Attachment No. _____

Dentist's signature _____

TRY-IN

ATTACHMENT NR. _____ Try-In _____ date ____/____/____

Notes _____

ATTACHMENT NR. _____ Try-In _____ date ____/____/____

Notes _____
