Dear Dr. _____, Date: _____

Patient: _____

Telephone:_____ Birthdate:_____

Please confirm the following:

Partial design OK - **YES NO**

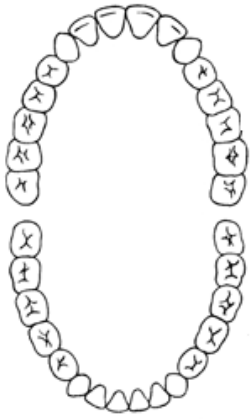
Stability of remaining natural teeth OK - **YES NO**

Hygiene completed - **YES NO**

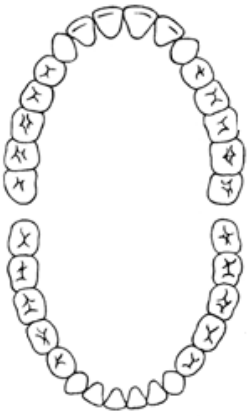
Rest Preps required - **YES NO**

- Completion date _____

PROPOSED DESIGN



ALTERNATIVE DESIGN



Signed_____D.D.S. Date: _____

Please fax back as soon as your convenience allows so we may continue treatment.