

SUITE 3 PROSPECT HOUSE, 3A ST. THOMAS PLACE, ELY - CB7 4EX ENGLAND  
 MOBILE +44 7928 478 267  
 EMAIL INFO@MAJESTICSMILE.CO.UK  
 WWW.MAJESTICSMILE.CO.UK

Dentist`s Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Date sent: \_\_\_\_\_ Date Required: \_\_\_\_\_

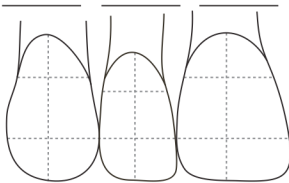
Patient`s Name Mr/Mrs/Ms: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female

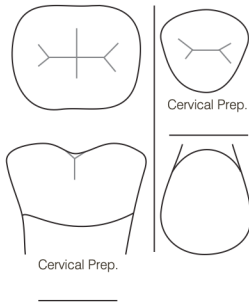
Sterile:  Impressions  Bite  Other \_\_\_\_\_

### Shade & Characteristics:

Cervical Prep. Cervical Prep. Cervical Prep.



Body Prep. \_\_\_\_\_



### Surface Anatomy:

Smooth  Medium  Heavy

### Incisal:

Flat  Incisal characteristics  Mammalon Developments

### Incisal Translucency:

Heavy  Medium  Light  None

Incisal Halo  Incisal Checklines

Blend cervical to Prep. Shade

Smile Evaluation form completed and enclosed

### Incisal Translucency:

Heavy  Medium  Light  None

Occlusal Halo

Blend cervical to Prep. Shade

Fissure Stain Colour: \_\_\_\_\_

Hypocalcification marks

Body Prep: \_\_\_\_\_

### Prescription of Service:

Dr`s Signature \_\_\_\_\_

**Statement:** When signed and dated below by Majestic Smile Technician: \_\_\_\_\_, as detailed above, this device was manufactured for the exclusive use of the named particular patient for the specified Dental Practitioner and with described particular features. The product here packed conforms to the essential requirements set out in Annex 1 of the EC Medical Device directive 93/42/EEC, and if any of these requirements are not fully met the details are documented on reverse or attached and dispatched to the user:

Signed:

Date: