



4411-4413 Poplar Level Rd. · Louisville, KY 40213
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ADLDental.com

Ivotion Rx

ATTN: _____ ACCOUNT#: _____

Today's Date _____ Due Date* _____

* FOR DELIVERY BY 5PM. If no due date is assigned, a standard MicroDental due date will be applied.

DOCTOR INFORMATION

Name _____

Address _____

Phone _____ Email _____

PATIENT INFORMATION

Name _____

Appointment Date _____ Sex _____ Age _____

INVENTORY SENT WITH CASE

- ☐ Impression: Upper & Lower ☐ Articulator ☐ Photos:
☐ Bite ☐ Shade Tab ☐ Attached
☐ Other: _____ ☐ Facebow ☐ Emailed to frontoffice@adldental.com

INSTRUCTIONS ☐ CALL ME BEFORE PROCEEDING WITH CASE

PLEASE SEND

- ☐ Rx forms
☐ FedEx Airbills
☐ UPS Airbills
☐ Boxes

FOR LAB USE ONLY

► Fill out, save as PDF, and use your "Attach Files" feature in your IOS software to attach and send Rx with scan files.

Dentist's Signature (Required) _____ License # (Required) _____

Person signing this authorization accepts sole responsibility for payment and agrees to pay all legal and collection costs in the event of suit, including reasonable fees. By law, dentist's signature will authorize MicroDental Laboratories to construct, alter, or repair the restoration described on this requisition.

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WORKFLOW

- ☐ Denture
☐ Partial
☐ Overdenture
☐ Copy Denture
☐ Duplicate Denture
☐ Return Existing Denture (if no IOS)
☐ Reference Denture
☐ Monobloc Trial Denture
☐ Immediate Denture

ADDITIONAL SERVICES

- ☐ Impression Tray
☐ Bite Plate & Wax Occlusion Rim

JAW SELECTION

- ☐ Maxillary
☐ Mandibular

IMPRESSION TYPE

- ☐ Traditional Impression
☐ IOS Scan

IMPLANTS

Ivotion Implant Prosthetic

- ☐ Implant-Retained
☐ Stud _____
☐ Implant-Supported
☐ Bar _____

PARTIAL (Select the missing teeth)

Teeth Numbers

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

SHADE (Select the correct shade)

A1	A2	A3	A3.5	BL3	B1	C1	C2	C3	C4
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GINGIVAL SHADE

☐ Preference (Pink) ☐ OUS-D (Dark)

SHAPE (Type)

☐ ☐ ☐

ALAMETER (Tooth Size)

☐ Small ☐ Medium ☐ Large

DENTURE GAUGE

Vertical _____ mm
Horizontal _____ mm

PAPILLAMETER

Vertical _____ mm

Ivotion Implant Parts

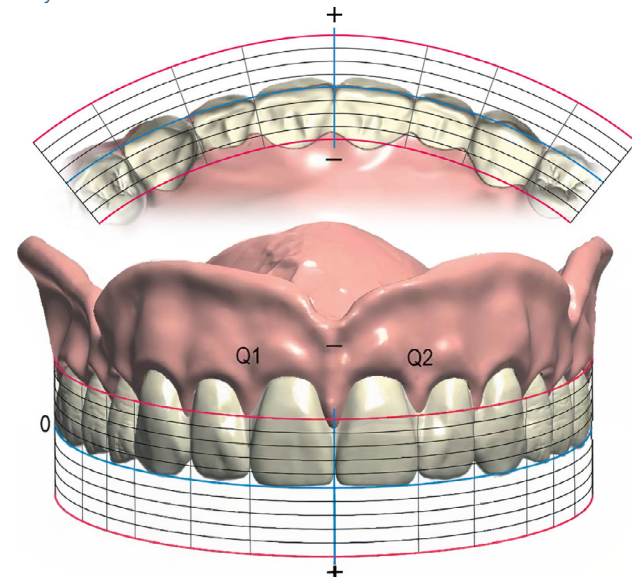
System _____ Implant Sites _____

Diameter _____

Lab to Order: ☐ Yes ☐ No

V-DIAGRAM

Please enter any desired modifications for the next step (try-in/definitive denture) here. Mark desired modifications of the Incisal length or vertical position for each individual anterior tooth. Please click directly on the lines.



Grid Vertical Line = 1mm