

1. Active credit card on file.

We don't do any billing. We will send a form to you to fill out and sign for this.

2. Accurate Impressions

If the restoration fits the model and not the mouth that means that the impression was not accurate, in which case there will be a 50% charge to redo the case.

Any crowns that might fracture needs to be sent back and will be redone at no charge.

For E.max crowns the minimum thickness is no less than 1mm and must be bonded to get the clinical statistics for strength

Minimum reduction requirement for full zirconia crowns is 0.5mm

3. Special Requests

If there are any special requests such as denture rests, articulation with high end products such as the Sam III, Denar, Kois etc, preparations copings, etc there will be an additional charge. Please see price list.



Solid Monolithic Zirconia, Emax Smile Designs and Implant Retained Hybrid Restorations

- * All Zirconia **FULL Monolithic** screw retained implant bridge with pink ceramic layering AND Temporary PMMA \$9600 + implant parts (doctor supplies) **BEST VALUE**
- * Please note the PMMA and Zirconia will be charged fully when we receive the 1st impression with 50% of the total cost to be either charged to your credit card or you can send a check with the The balance will be due after PMMA approval and before starting the final zirconia.
- * **Longer term transitional PMMA** (the longevity varies depending on the thickness of PMMA and the vertical height) \$4,000 + parts (doctor supplies) - flat fee
- * If 2nd set PMMA is needed it is only \$150 per tooth.

SMILE DESIGNS

- * Solid Zirconia Smile Designs including Crowns, bridges, veneers.....\$450 per tooth
- * Wax up for **POP IN SMILE**, including silicone index,\$100 per tooth or \$1,000 full arch
- * Bridges.....\$650 per tooth
- * Smile Design Milled Temporaries\$250 per tooth
- * 2nd set it needed.....\$150 per tooth

PLEASE NOTE: WE DO NOT DO SINGLE CENTRALS OR LATERALS

******SHIPPING — ONE WAY IS INCLUDED IN THE PRICE******

Please note that we do not do any billing. Either a check can be enclosed with the case or an active credit card can be kept on file that will be charged when the impression is received. Please fill out the form below to allow us to do this. Either fax this form to (770)984-9007 or enclose with your first case.

Method of Payment		<input type="checkbox"/> Visa	<input type="checkbox"/> Master Card	<input type="checkbox"/> Check
		<input type="checkbox"/> American Express	<input type="checkbox"/> Discover Card	
Name on Card	_____		Card Exp.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
			Sec. Code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Credit Card Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Billing Zip Code	_____
<p>Pursuant to this agreement with Adar Dental Network, Inc., I agree that I have authorized the payment method, selected above to be fully charged upon receipt of digital/conventional impression by Adar Dental Network, Inc. I agree to be bound by the terms and conditions set forth by Adar Dental Network, Inc. Clients of ADN are independent DENTISTS and are free to sell the product at whatever retail price they desire.</p>				
Signature _____			Date _____	



VIP
DENTISTS
ONLY

LAB PRESCRIPTIONS

SHIPPING: 2100 RiverEdge Parkway, Suite 1040
Atlanta, Georgia 30328
1.800.510.9286
1.770.980.9286
INFO@ADAR.NET
WWW.ADAR.NET

Doctor's Name	Patients Name		
Doctor's Address	Age	Sex	
City	State	Zip	Shade Needed
Phone Number	Laminate Purpose		Surface Texture
License Number	<input type="checkbox"/> Alignment <input type="checkbox"/> Shade Change		<input type="checkbox"/> Smooth
Date Ordered	<input type="checkbox"/> Diastema Closure <input type="checkbox"/> Recontouring		<input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
Requested Due Date	Tetracycline, Fluorosis Stain <input type="checkbox"/> Coverage (Indicate on drawing)		Dental Operator
Dr's Signature	Incisal Wrap <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Length <input type="checkbox"/> 1/2 mm <input type="checkbox"/> 1 mm <input type="checkbox"/> 1 1/2 mm	

RECOMMENDED QUESTIONS

Required (All enclosed items will be returned)

1. How do you feel about your temps?

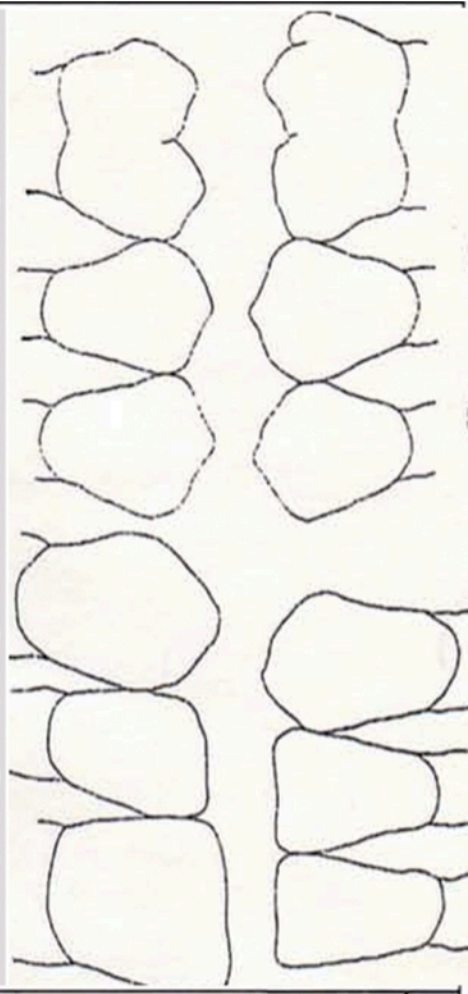
<input type="checkbox"/> Impressions	<input type="checkbox"/> Master Model
<input type="checkbox"/> Opposing Model	<input type="checkbox"/> Procera Crown
<input type="checkbox"/> Study Model	<input type="checkbox"/> Porcelain Crown
<input type="checkbox"/> Bite	<input type="checkbox"/> P.F.M. Crown
<input type="checkbox"/> Modified Guide	<input type="checkbox"/> Dies
<input type="checkbox"/> Inlays/Onlays	<input type="checkbox"/> Photos/Slides
<input type="checkbox"/> Porcelain Laminates	<input type="checkbox"/> Custom Made Chip

2. What is your color preference?

3. Do you like the staining around the necks?

4. Do you like the shape of your natural teeth?

5. Which part of your natural teeth do you like?



Date Received

Sch. Ship Date

Date Shipped