Rothan Dental Lab, Inc.
Case Evaluation Form

Dr._____ Seating Date_____

Patient Name_____Type of Restoration_____

(Please circle - scale 0 to 10) Open (0) Good (5) Heavy (10)

Occlusal Contacts 0 1 2 3 4 5 6 7 8 9 10

Interproximal Contacts - Distal 0 1 2 3 4 5 6 7 8 9 10

Interproximal Contacts - Mesial 0 1 2 3 4 5 6 7 8 9 10

Margins_____ Shade_____

Overall Satisfaction / Additional Comments _____

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_____

Thank you so much for your feedback. Our goal is continuous improvement.