

Doctor Name

Harmony Dental Laboratory

Quality Assurance Scorecard

Date

Patient Name

FIXED PROSTHETICS

Type of Case

In-Lab Final Quality Check

Overall Fit to Model	<input type="radio"/>
	Per Preferences
Occlusion	<input type="radio"/>
	Per Preferences
Interproximal Contacts	<input type="radio"/>
	Per Preferences
Marginal Accuracy Checked	<input type="radio"/>
	Under Magnification
Shade Accuracy	<input type="radio"/>
	Per Rx
Anatomy & Contour	<input type="radio"/>
	Natural
Prescription Followed	<input type="radio"/>
	Yes
Comments _____	

Quality Checked By: _____	

Chairside Quality Check

Overall Fit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Tight	Good	Passive
Occlusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	High	Good	Infra
Interproximal Contacts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Heavy	Good	Light
Marginal Accuracy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Overextended	Good	Short
Shade Accuracy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Dark	Good	Light
Anatomy & Contour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Too Much	Natural	Too Little
Prescription Followed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Yes	No	
Patient Satisfaction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Happy	Satisfied	Acceptable
Total Seating Time _____ minutes			
Comments: _____			