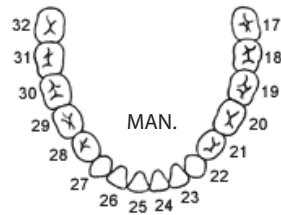
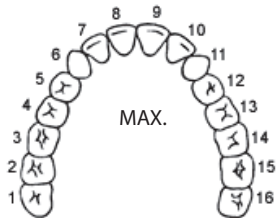




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Doctor: _____
 Patient: _____ Age: ____ M or F
 Date Required: _____ by 5:00 p.m. Try in Finish
 Custom Tray _____ Wax Rim _____ Set Up _____ Reset _____

Upper Denture <input type="checkbox"/>	Lower Denture <input type="checkbox"/>	Immediate Denture <input type="checkbox"/>		Economy Denture <input type="checkbox"/>	
Shade _____	Degree of Posterior Tooth	0°	10°	20°	33°
Flipper: (1-4 teeth)	Acrylic	Wrought Wire Clasps Where Needed <input type="checkbox"/> Yes <input type="checkbox"/> No	OR	Flexible TCS	
Partial Denture:	Cast-metal Framework	Acrylic	Flexible TCS	Immediate	
Night Guards/Splints:	Hard	Soft		Hard/Soft	
Oral Appliance for Obstructive Sleep Apnea:			EMA Custom		
Hard Reline	Soft Reline	Mouth Guard	Bleaching Tray	Surgical Tray	
Tissue/Material Color:	Lucitone 199	Lucitone Light	Medium	Dark	
Finish Instructions:	Smooth	Stipple	Custom Stain		



Instructions:

Authorized Signature _____

License Number _____

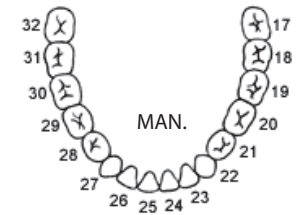
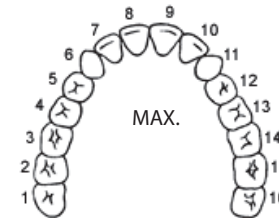
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Authorized Signature _____

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