

DATE _____

DR _____ ASSISTANT _____

ADDRESS _____ CITY/STATE _____

PATIENT'S NAME _____ MALE _____ FEMALE _____

DUE BY 5:00 PM ON _____ AGE _____

SHADE _____ TYPE OF TEETH _____ MOULD _____

DENTURE DEPT

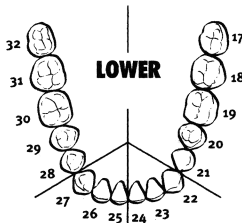
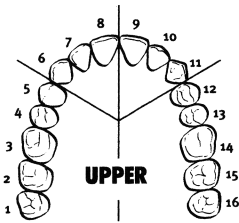
- UPPER LOWER
- Custom Tray
- Wax Rim
- Immediate
- Implant Denture
- Flipper (No Clasp)
- Acrylic Partial W/Clasp
- Flexible Partial
- CLEARSplint® w/Flex

DENTURE (CHOOSE ONE)

- Economy - Acupac® Acrylic
- Premium - Lucitone 199® Acrylic
- Elite - IvoBase® Acrylic
- Digital - Lucitone Print Dentures
 - carded teeth
 - printed teeth

SELECT LEVEL OF COMPLETION

- Wax Set-Up & Try-In
- Set-Up & Finish
- Process & Finish



PARTIAL FRAMEWORKS

Cast Vitallium®

- Frame Only
- Frame w/Wax Rim
- Frame w/Teeth set-up
- Frame w/Teeth Set-up & Finish

SELECT TISSUE SHADE (Lucitone 199® Acrylic)

- Original
- Lt. Pink
- Lt. Reddish Pink
- Dark Pink
- Clear
- Other _____

LAB USE ONLY	
_____	CHK IN
_____	MODEL
_____	CT/WR
_____	THSL
_____	S-UP
_____	W-UP
_____	PRCS
_____	FMS
_____	PLSH
_____	RPR
_____	QC

REPAIRS & RELINES

- Replace tooth # _____
- Repair fracture
- Strengthen Bar
- Mesh
- Rebase (New Acrylic)
- Reline Hard Soft

CLASPS

- Ball Clasp
- Wrought Wire Clasp
- Clear Flexi Clasp

PLEASE SEND:

- RX FORMS
- BOXES
- RETURN LABELS

Notes _____

Call Dr. _____

Photo Sent _____

Signature _____ License # _____

