Removable Prosthetic RX

Required Information

Doctor Name _____

Practice Name _____

Address _____

Phone _____

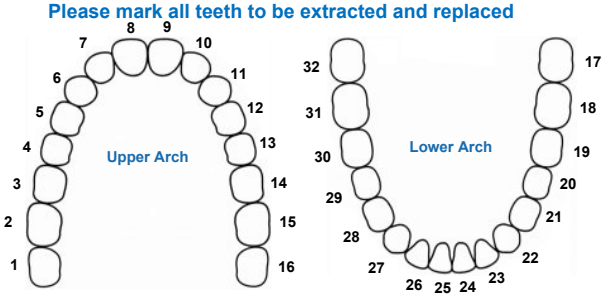
Patient Name_____

M F Age_____

Due Date_____

Extractions

Please mark all teeth to be extracted and replaced



Dentures

☐ Upper ☐ Lower ☐ Both

☐ Custom Tray ☐ Set-up/Try-in
☐ Bite Rim ☐ Immediate/surgical Denture
☐ Finish

_____

Partials

☐ Upper ☐ Lower ☐ Both

☐ Custom Tray ☐ Set-up/Try-in
☐ Bite Rim ☐ Finish

Nightgaurds/Splint

☐ Upper ☐ Lower

☐ Polysplint (Harvest)
☐ Thermeo (pro3dure) (Recommended)

Other

☐ Hard Reline ☐ Simple Repair
☐ Complex Repair

Case Design

Acrylic Shade (Required)

☐ Original (Luc. 199) ☐ Light Reddish Pink (Luc. 199) ☐ Light Pink (Luc. 199) ☐ Dark Pink (Luc. 199)

Tooth Shade: _____ Shade Guide used: _____

RX Specific Instructions

Please provide any photos, study models, diagnostic casts with case. Email photos to amkdental14@gmail.com

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Dentist signature _____ (Required)
Dentist License no. _____ (Required)