

DENTAL PROSTHETIC SERVICES

Removable Rx



Doctor: _____ **Patient:** _____
Phone: _____ **Age:** Youthful Middle-Age Mature
Address: _____ **Gender:** Female Male
City/State/ZIP: _____ **Tooth #:** _____ **Shade:** _____
Contact for case questions: _____
Contact email: _____ **Email can be used for case questions?** Yes No
Special Delivery Instructions: _____

Full Denture	
Select Denture Type	
Traditional	or Printed
<input type="checkbox"/> Value Line <input type="checkbox"/> Integrity Line <input type="checkbox"/> Ultra Line	<input type="checkbox"/> Simplicity
Select Teeth	Select Tooth Shade
<input type="checkbox"/> Ivoclar Ivostar/ Gnathostar® <input type="checkbox"/> Ivoclar BlueLine® <input type="checkbox"/> Ivoclar Phonares®	<input type="checkbox"/> Printed Teeth A1, A2, A3, B1 (Circle one)
Select Material Color	Select Material Color
<input type="checkbox"/> Ivocap Medium Pink Fibered (Standard) <input type="checkbox"/> Meharry (Ethnic)	<input type="checkbox"/> Reddish Pink (Standard) <input type="checkbox"/> Dark Pink (Ethnic)
	Post Dam
	<input type="checkbox"/> Yes (Standard) <input type="checkbox"/> No

Processed base Light cure base
 Bite block Pin tracer
 Set up/Try in **Finish case**

Other
 Personal ID Patient specific tray

Deliver by 5:00pm on _____

Partial Denture
 Design and estimate only
 Design, estimate, and patient specific tray

Cast Frame Partial
 Conventional clasping
 Saddle-Lock (Hidden clasp)
 Composite facings (Indicate teeth on diagram below)

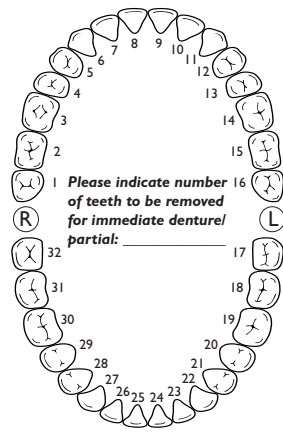
Frame only Frame & teeth
 Frame & bite registration
 Try in **Finish case**

Composite/Acrylic Partial
 Dura-Temp bridge (Stainless steel wings/composite)
 Flipper (Acrylic partial)
 Number of clasps: _____
 Softseal partial

Flexible Partial
 DuraFlex™ Valplast®

Select Teeth
 Ivoclar Ivostar/Gnathostar®
 Ivoclar BlueLine® Ivoclar Phonares®

I would like a phone call regarding instructions



DENTAL PROSTHETIC SERVICES
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 www.DPSdental.com
Please send my office:
 Rx Fixed Rx Sleep
 Rx Removable Rx Implants
 Rx Ortho Boxes
 UPS/Mailing Labels

Doctor Signature: _____
 (Please select shade, age, gender, and delivery date)