



Dr. Name \_\_\_\_\_ Phone \_\_\_\_\_

Patient Name \_\_\_\_\_ License Number \_\_\_\_\_

DOB \_\_\_\_\_ Prep date \_\_\_\_\_

Male  Female  Other \_\_\_\_\_ Due date \_\_\_\_\_

## REMOVABLES RX

### PARTIAL DENTURE

**Instructions:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Flexible Partial:</b> | <input type="checkbox"/> <b>Framework:</b> | <input type="checkbox"/> Anterior/ posterior coverage |
| <input type="checkbox"/> Set up with teeth        | <input type="checkbox"/> Bite rim          | <input type="checkbox"/> Posterior coverage           |
| <input type="checkbox"/> Set up and finish        | <input type="checkbox"/> Try-in            | <input type="checkbox"/> Design & estimate only       |
| <input type="checkbox"/> Acetal resin             | <input type="checkbox"/> Set up            |   |
|   | <input type="checkbox"/> Setup and finish  |   |
|   | <input type="checkbox"/> Acetal resin      |   |

**Clasps:**

- |  |                                       |                                       |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> As survey indicates | <input type="checkbox"/> Acetal resin | <input type="checkbox"/> Akers        |
| <input type="checkbox"/> Bent wire           | <input type="checkbox"/> RPI          | <input type="checkbox"/> Roach        |
| <input type="checkbox"/> ClearMet            |                                       | <input type="checkbox"/> Other: _____ |

**Connector:**

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Horseshoe   | <input type="checkbox"/> Palatal bar   | <input type="checkbox"/> Double palatal bar |
| <input type="checkbox"/> Lingual bar | <input type="checkbox"/> Lingual Plate | <input type="checkbox"/> Double lingual bar |

**Material:**

- |  |   |                                   |
|--|---|-----------------------------------|
| <input type="checkbox"/> Metal ( Chrome cobalt, nickel free) | <input type="checkbox"/> Standart acrylic | <input type="checkbox"/> Valplast |
|  | <input type="checkbox"/> Acetal resin     |                                   |

### FULL DENTURE

**Instructions:**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Custom tray  | <input type="checkbox"/> Bite rims      | <input type="checkbox"/> Anterior setup |
| <input type="checkbox"/> Setup try-in | <input type="checkbox"/> Surgical stint |   |

**Type of case:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> All-on-X        | <input type="checkbox"/> Trefoil         | <input type="checkbox"/> Retread              |
| <input type="checkbox"/> Full            | <input type="checkbox"/> Immediate       | <input type="checkbox"/> Repair               |
| <input type="checkbox"/> Hard reline     | <input type="checkbox"/> Soft reline     | <input type="checkbox"/> Reproduce/ rebase    |
| <input type="checkbox"/> Hard nightguard | <input type="checkbox"/> Soft nightguard | <input type="checkbox"/> Hard/soft nightguard |

**Tissue:**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Standard (pink) | <input type="checkbox"/> Ethnic (Moderate) | <input type="checkbox"/> Other: _____ |
|--|--|---------------------------------------|

**Finish:**

- |                                  |   |                                  |
|----------------------------------|---|----------------------------------|
| <input type="checkbox"/> Stipple | <input type="checkbox"/> Rugae          | <input type="checkbox"/> Postdam |
| <input type="checkbox"/> Smooth  | <input type="checkbox"/> Palatal relief |                                  |

**Implants:**

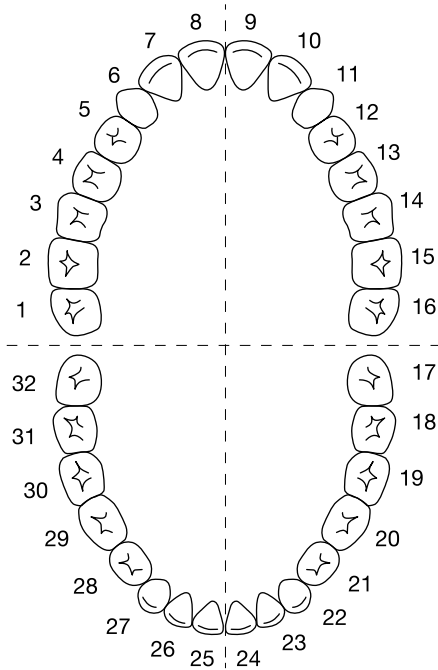
Type: \_\_\_\_\_  
Diameter: \_\_\_\_\_

**Implant bar material:**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Titanium      | <input type="checkbox"/> Gold         |
| <input type="checkbox"/> Chrome Cobalt | <input type="checkbox"/> Other: _____ |

**Type of bar:**

- |                                   |                                   |                                       |
|-----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Full rep | <input type="checkbox"/> Paris    | <input type="checkbox"/> Dolder       |
| <input type="checkbox"/> Hader    | <input type="checkbox"/> Montreal | <input type="checkbox"/> Other: _____ |



Upper Shade: \_\_\_\_\_  
 Lower Mold: \_\_\_\_\_

**Teeth type:**

- |   |   |
|---|---|
| <input type="checkbox"/> Ivostar          | <input type="checkbox"/> Ivoclar Vivadent |
| <input type="checkbox"/> Ivoclar Phonares | <input type="checkbox"/> Other: _____     |

**Denture type:**

- |                                 |                                  |
|---------------------------------|----------------------------------|
| <input type="checkbox"/> Analog | <input type="checkbox"/> Digital |
|---------------------------------|----------------------------------|

**Notes** (if you need more space use other side of sheet):

Signature \_\_\_\_\_

*If any selections are left unmarked, the technician will make a decision based on their professional judgment.*