

REMOVABLE RESTORATIONS RX



841 BOARDMAN CANFIELD RD.
SUITE 310
BOARDMAN, OH 44512

Your Reference # _____

Doctor _____

Patient Name _____

Date Sent _____ Due Date _____

PARTIAL DENTURES

<p><u>PARTIALS WITH FRAMES</u></p> <p><input type="checkbox"/> CoCr <input type="checkbox"/> Vitallium</p> <p><input type="checkbox"/> FRAME ONLY</p> <p><input type="checkbox"/> FRAME BITE BLOCK/RIM</p> <p><input type="checkbox"/> FRAME W/TEETH SET UP</p> <p><input type="checkbox"/> FRAME/SETUP/FINISH</p> <p><input type="checkbox"/> RESET TEETH ONLY</p> <p><input type="checkbox"/> PROCESSING</p> <p><u>TYPE OF ACRYLIC</u></p> <p><input type="checkbox"/> CONVENTIONAL</p> <p><input type="checkbox"/> GC AMERICA</p> <p><input type="checkbox"/> VALPLAST</p>	<p><u>PARTIALS ALL ACRYLIC</u></p> <p><input type="checkbox"/> TEETH SET UP FINISH ALL ACRYLIC</p> <p><input type="checkbox"/> WAX TRY-IN ALL ACRYLIC</p> <p><input type="checkbox"/> PROCESSING ALL ACRYLIC</p> <p><input type="checkbox"/> ADD TOOTH ALL ACRYLIC</p> <p><input type="checkbox"/> RESET TEETH ALL ACRYLIC</p> <p><u>TYPE OF ACRYLIC</u></p> <p><input type="checkbox"/> Valplast</p> <p><input type="checkbox"/> GC AMERICA</p> <p><input type="checkbox"/> DURAFLEX</p>	<p><u>OTHER</u></p> <p><input type="checkbox"/> ADD TOOTH # _____</p> <p><input type="checkbox"/> ADD WIRE CLASP # _____</p> <p><input type="checkbox"/> ADD CAST CLASP # _____</p> <p><input type="checkbox"/> VALPLAST CLASP # _____</p> <p><input type="checkbox"/> CLEAR CLASP # _____</p>	<p>Items Sent: (Circle all that apply)</p> <table style="width:100%;"> <tr> <td>Single Tray</td> <td>Triple Tray</td> <td>Study Model</td> </tr> <tr> <td>Upper Model</td> <td>Lower Model</td> <td>Bite Block</td> </tr> <tr> <td>Bite</td> <td>Wax with Teeth</td> <td>Articulator</td> </tr> <tr> <td colspan="3">Frame</td> </tr> </table> <p>Other _____</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><u>FRAMEWORK DESIGN</u></p> <p><input type="checkbox"/> LAB TO DESIGN</p> <p><input type="checkbox"/> SEE DRAWING ON RX</p> <p><input type="checkbox"/> SEE DRAWING ON CAST</p> </div> <div style="width: 45%;"> <p><u>TOOTH SHADE</u></p> <p>_____</p> <p><u>ACRYLIC SHADE</u></p> <p>_____</p> </div> </div> <p><input type="checkbox"/> MESIAL REST(S) ON _____</p> <p><input type="checkbox"/> DISTAL REST(S) ON _____</p> <p><input type="checkbox"/> CINGULUM REST(S) ON _____</p>	Single Tray	Triple Tray	Study Model	Upper Model	Lower Model	Bite Block	Bite	Wax with Teeth	Articulator	Frame		
Single Tray	Triple Tray	Study Model													
Upper Model	Lower Model	Bite Block													
Bite	Wax with Teeth	Articulator													
Frame															

FULL DENTURES

<p><u>FULL DENTURES</u></p> <p><input type="checkbox"/> SET TEETH TRYIN</p> <p><input type="checkbox"/> PROCESSING</p> <p><input type="checkbox"/> SET TEETH & PROCESSW/GC AMERICA</p> <p><input type="checkbox"/> SET TEETH & PROCESS W/Lucitone 199</p> <p><input type="checkbox"/> PROCESSWITH GC AMERICA</p> <p><input type="checkbox"/> TCS SUCTION CUP</p>	<p><u>IMMEDIATE DENTURES (Extract All Teeth)</u></p> <p><input type="checkbox"/> IMMEDIATE TEETH SET UP FINISH</p> <p><input type="checkbox"/> IMMEDIATE WAX TRY-IN</p> <p><u>TYPE OF ACRYLIC</u></p> <p><input type="checkbox"/> GC AMERICA <input type="checkbox"/> LUCITONE 199</p>
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DIGITAL DENTURE

OTHERS

- ☐ TIER1 Executive
- ☐ TIER1 Economy

- ☐ ACRYLIC FLIPPER(2171)
- ☐ SPACE MAINTAINER(2909)
- ☐ BASE PLATE/BITE RIM(2911)
- ☐ NIGHT GUARD SOFT(2921)
- ☐ NIGHT GUARD HARD(2922)

REMAKE INFORMATION

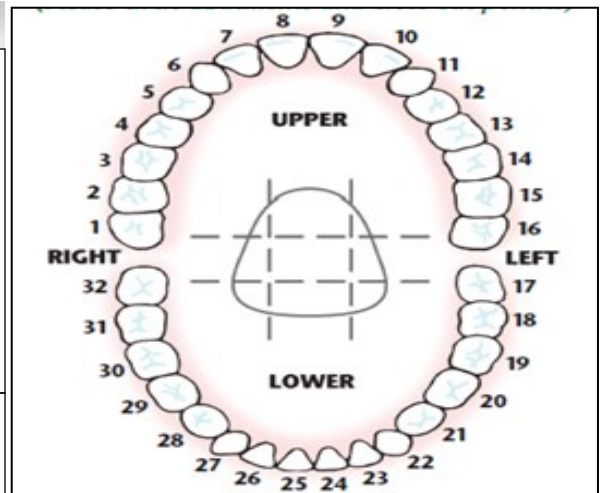
(Please complete this section if returning this case for a remake)

Customer Original Pan # _____ PLS Original RX # _____

Reason for Remake _____

Items being Returned

- ☐ Original Prosthesis (Partial, Bite, Etc.)
- ☐ Original Model Original Die Original PLS RX
- ☐ Old Impression New Impression Study Model
- (Failure to provide original RX, reason, or items may result in a delay in processing this case and a charge for this remake)*



SELECT WORK TO BE MADE

UPPER LOWER

OTHER SPECIAL INSTRUCTIONS