

Baytek Dental Lab DL# 11511

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Rx Date :
Date Due in Office :
<small>(Deliver By 5PM)</small>

Doctor's Name _____ (Please Print)

Doctor's Address _____

Patient's Name _____

M F
 Sex _____ Age _____

REMOVABLE RESTORATIONS (Please)

Dentures
<input type="checkbox"/> Custom Tray
<input type="checkbox"/> Base Plate/Wax Rim
<input type="checkbox"/> Duplicate Wax Denture
<input type="checkbox"/> Economy Denture
<input type="checkbox"/> Premium Denture
<input type="checkbox"/> Heat Cure - Night Guard
<input type="checkbox"/> Immediate Denture
<input type="checkbox"/> Denture Set-Up
<input type="checkbox"/> Denture Finish

UPPER LOWER

Acrylic Partials
<input type="checkbox"/> Set Teeth for Wax Try-In
<input type="checkbox"/> Process & Finish
<input type="checkbox"/> Add Tooth # _____
<input type="checkbox"/> Add Clasp (Wrought Wire or Ball Clasp)
<input type="checkbox"/> Acrylic Flipper (1-2 Teeth)

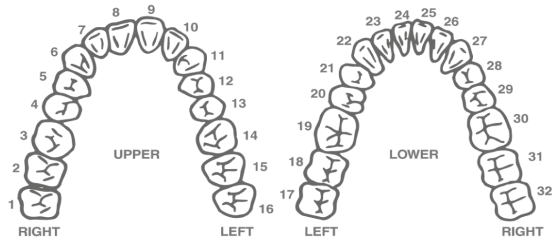
Acrylic Type
<input type="checkbox"/> Nobiltone Pink
<input type="checkbox"/> Nobiltone Hi-Impact (extra charge)
<input type="checkbox"/> Meharry
<input type="checkbox"/> Clear

Repairs / Relines
Relines
<input type="checkbox"/> Hard <input type="checkbox"/> Soft
Repairs
<input type="checkbox"/> Tooth <input type="checkbox"/> Fractures
<input type="checkbox"/> Clasp

Shade
Tooth Shade _____
Tooth Mold _____

Items Sent
<input type="checkbox"/> Models
<input type="checkbox"/> Bite Block
<input type="checkbox"/> Photos
<input type="checkbox"/> Bite Registration
<input type="checkbox"/> Study Model
<input type="checkbox"/> Other _____

Rx SPECIFIC INSTRUCTIONS :



Doctor's Signature _____ Lic. # _____