

HIAWATHA, ANKENY, & DAVENPORT 319-298-9800 | MASON CITY 641-380-0362

DOCTOR: _____ PHONE: _____

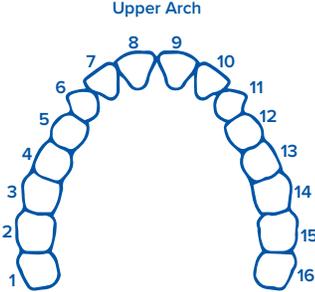
PATIENT: _____

DATE SENT: _____ WANTED: _____

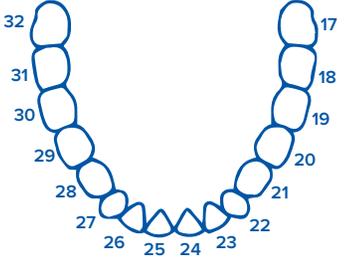
PLEASE CALL DOCTOR BEFORE STARTING THIS CASE

CASE DESIGN

Upper Arch



Lower Arch



Please mark all teeth to be extracted or to be replaced

- Follow the doctor's design
- Best design for fit and function
- Follow Try in/ Previous Denture
- Light Meharry

Acrylic Shade

Ivocap Preference Ivocap US Dark

Shade _____ Mould no. _____

Rx

TOOTH NUMBER

Removable Prosthetics Rx

DENTURES

<input type="checkbox"/> Upper	<input type="checkbox"/> Try-In	<input type="checkbox"/> Premier™ Denture	<input type="checkbox"/> Custom tray
<input type="checkbox"/> Lower	<input type="checkbox"/> Finish*	<input type="checkbox"/> Economy Denture	<input type="checkbox"/> Base plate
<input type="checkbox"/> Cast metal base	<input type="checkbox"/> Immediate/Surgical Denture	<input type="checkbox"/> Occlusal rim	
<input type="checkbox"/> Metal mesh	*Standard design if an option is not selected		

PARTIALS

<input type="checkbox"/> Upper	<input type="checkbox"/> Lower	<input type="checkbox"/> Try-in*	<input type="checkbox"/> Finish
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Base Material

<input type="checkbox"/> Acrylic	<input type="checkbox"/> Custom tray
<input type="checkbox"/> VisiClear	<input type="checkbox"/> Base plate
<input type="checkbox"/> Valplast*	<input type="checkbox"/> Occlusal rim
<input type="checkbox"/> Immediate/surgical	

Partial Design

<input type="checkbox"/> Cast metal framework only	<input type="checkbox"/> Cast metal framework w/ bite rim	<input type="checkbox"/> Full palatal metal coverage (upper)
<input type="checkbox"/> Vitallium Cast frame	<input type="checkbox"/> Acetal	<input type="checkbox"/> Lingual bar (lower)
<input type="checkbox"/> Horseshoe palate (upper)	<input type="checkbox"/> Wrought wire clasps	<input type="checkbox"/> Cosmetic clasp <input type="checkbox"/> Cast clasp
<input type="checkbox"/> Lingual apron (lower)	<input type="checkbox"/> A-P strap	<input type="checkbox"/> Ball clasps

Tooth Type

<input type="checkbox"/> Economy	<input type="checkbox"/> Premier
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OTHER

<input type="checkbox"/> Upper	<input type="checkbox"/> Soft	Night Guards/Bite Splints	Other
<input type="checkbox"/> Lower	<input type="checkbox"/> Hard (Clear acrylic)	<input type="checkbox"/> FlexiGuard™ (Hard-soft)	<input type="checkbox"/> Reline
	<input type="checkbox"/> Sports guard	<input type="checkbox"/> Basic Repair	<input type="checkbox"/> Rebase
		<input type="checkbox"/> Soft liner	<input type="checkbox"/> Complex Repair
			<input type="checkbox"/> Add clasp
			<input type="checkbox"/> Patient ID

ENCLOSED

Photo Communication: Full Face Profile Repose Rest Intra oral

CD/USB Images emailed Sent w/ case

Enclosed w/ Case: Impression Alginate Models Bite Facebow

Impression transfers Faceshow Abutment Other _____

NOTE: PLEASE SEND A STUDY MODEL ON ALL WORK INVOLVING ANTERIOR TEETH
(Cost of Collection of any Account will be paid by the Customer)

Signature : _____ D.D.S. License # _____

Please send more Rx Forms Send more boxes Other