Dr:_____ Date:_____

Address:_____

City:_____ State:_____

Phone:_____ ZIP:_____

Patient:_____ Age:_____

☐ Male ☐ Female ☐ Use Name for Patient I.D.

Request Return Date:_____ Time:_____

ENCLOSED WITH CASE

☐ Impression ☐ Master Model ☐ Opposing Model ☐ Bite Relation

☐ Facebow ☐ Articulator ☐ Framework ☐ Old Crown

☐ Attachment ☐ Implant Components ☐ Photos

Other:_____

FULL DENTURE

☐ Upper ☐ Lower ☐ Immediate ☐ Set-up

☐ Reset ☐ Process ☐ Intraoral Tracer ☐ Bite rim

☐ Processed Base ☐ Patient-Specific Trays

DENTURE TEETH & FINISHES

☐ Artisan	☐ Premium	☐ Standard	☐ Economy
☐ Ivoclar **DCL**	☐ Ivoclar **DCL**	☐ **Artic**	☐ **Economy**
☐ TruByte IPN	☐ TruByte IPN		
☐ Candulor NFC+			
☐ Mondial i			

Shade Ant _____ Post_____ **Mould** Ant _____ Post_____

DENTURE BASE SHADE

Base Material: ☐ Standard ☐ Light Ethnic ☐ Med. Ethnic ☐ Dark Ethnic

DENTURE / PARTIAL SUPPORT SERVICES

☐ **Reline:** ☐ Hard ☐ Soft

☐ **Repair:** ☐ Base ☐ Tooth Tooth #: _____

☐ **Rebase**

☐ **Add clasp** ☐ **Cast** ☐ **Wire**

☐ **Add teeth**

Return White Copy Completed **Keep Yellow Copy For Your Files** **7/18**

edmonds Dental Prosthetics

2065 W Woodland • Springfield MO 65807 • 800.462.3569

417.881.8572 • Fax 417.881.0484

West Plains MO • 417.256.3474 • 800.582.2291

Jonesboro AR • 870.935.9094 • 800.752.7650

Made in the U.S.A.

Special Instructions: ☐ **Please call**

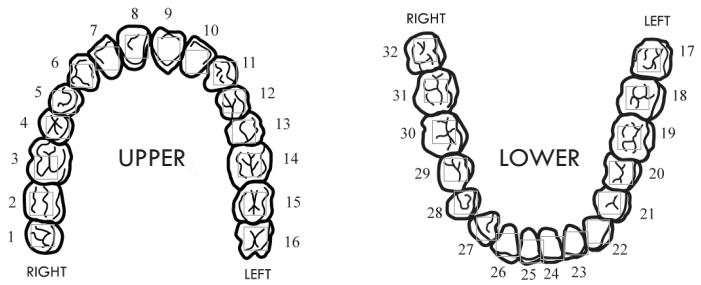
☐ Exception to doctor preferences

Has this case been disinfected? ☐ Yes ☐ No

Papilla meter High _____ Alma Gauge _____

Low _____ Vert_____ Horiz _____

Occlusal Scheme: _____



DENTURE SYSTEMS

☐ **Master Denture System** - Esthetic bite rim with intraoral tracer, characterized set-up, process, and patient identification.

IMPLANTS

WE SUPPORT ALL MAJOR IMPLANT SYSTEMS AND WILL BE HAPPY TO ASSIST YOU WITH YOUR IMPLANT NEEDS.

PARTIAL DENTURE

☐ **Wironium** (Our standard alloy)

☐ **Vitallium**

☐ **Economy**

☐ Conventional Design ☐ Wiro-Flex

☐ Hidden Bar Design ☐ Saddle Lock

☐ Nesbit Unilateral ☐ Swing Lock

☐ Frame Design Only ☐ Clear Clasp

☐ Frame Try-in ☐ Tooth Colored Clasp

☐ Frame/Wax Rim ☐ Pink Clasp

☐ Frame/Try-in Teeth

☐ Frame/Teeth Processed

Tooth #:_____ Shade: _____

(See Denture Teeth for Tooth Selection)

METAL-FREE

☐ E-FLX ☐ Baseplate/Wax Rim

☐ Valplast ☐ Try-in

☐ Flexite Plus ☐ Process

☐ Soft-Grip Partial

☐ Processed Acrylic

☐ Flipper (self-cure)

Replacing

Tooth #:_____

Shade:_____

Clasping

Tooth #:_____

☐ Cast ☐ Wire ☐ Clear ☐ Pink ☐ Tooth Color

(See Denture Teeth for tooth selection)

ORTHODONTICS

☐ **Maxillary** ☐ **Mandibular**

☐ Removable ☐ Occlusal Splint

☐ Fixed ☐ Hard

☐ See Design ☐ Soft

☐ See Notes

☐ Appliance:_____

☐ Color Request:_____

Payment is due upon receipt of statement. Payment <u>not</u> received by the end of the following month is subject to a 1.5% per month service charge unpaid balance plus all collection costs if incurred.
Your signature is acceptance of these terms.
Each prescription must be completed and signed.

X_____ _____

Doctor Signature *License Number*