

PATIENT PRESCRIPTION FORM

PATIENT PRE	Denture	
	Partial	
Fodays Date: _	 Immediate 	
Next appt		 Bite Splint
Due Date:	Time:	2.10 0011111

Universal Removable RX	Due Date: _	I ime:	- Other	
Doctor Information		and a		
Name:				
License #		Cath A.	200	
Patient Information		☐ Premium ☐ Sta	and Digital	
Name:		dth of the anterior teet	h	
Diagnostic Results Skin Type: Light Dark			he six anterior teeth ters	
Height approx/ Feet / Inc	hes	ngth of the anterior tee	th	
☐ Current Facial Picture☐ Earlier Facial Picture☐ Diagnostic Models of Existing Denture(s)	(eter reading eters	
Anterior Bite Relationship	Fra	amework		
□ Neutral □ Distal □ Mesial		Metal ☐ Try-in Flexible ☐ Finish	9 10 Framewor	
Additional Notes		3 UPPE	12 13 14 15	
 □ Prelim Imps. □ Custom Tray □ Framework □ Try-in □ Frameworks w/ Bite Ble □ Bite Back/Base Plate □ Framework w/ Teeth Tr □ Gothic Arch Tracer □ Framework Finish □ Set-up for Try-in □ Visual Try-in □ Reset □ Process & Finish 		1 R 32 LOWE 30 29 28 27 26 25 24	19 20 21	