

**DR NAME** \_\_\_\_\_ **PT NAME** FIRST \_\_\_\_\_ AGE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ LAST \_\_\_\_\_ FEMALE  MALE   
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_ **DUE DATE** FINISH \_\_\_\_\_ TRY IN \_\_\_\_\_

**DSO PRACTICE NAME** \_\_\_\_\_ **TODAY'S DATE** \_\_\_\_\_ **CALL ME**

(IF APPLICABLE)

**ENCLOSED WITH CASE:**  Model  Shade Tab  Bite  Impressions  Photo (Preferred)  Articulator  Metal Trays  Teeth  Other \_\_\_\_\_

**DENTURE**

U L  
 Occlusion Rim  
 Custom Tray  
 Other

**TEETH**

U L  
 Economy  
 Standard  
 Premium

**PARTIAL**

U L  
 Standard CRCO  
 Premium CRCO  
 with Occlusion Rim  
 Acrylic Partial  
 Flipper  
 Semi Precision  
 New Partial to fit Crown or Bridge

U L  
 Gold  
 VisiClear™  
 Valplast®  
 Flexible

**ANTERIOR SET-UP**

Ideal  Characterized  Study Model

**CHECKLIST**

Midline Marked  High Lip Line  
 Proper Lip Support  Emergency (Spare Denture)  
 **Name/Identifier in Appliance**

**SPLINT**

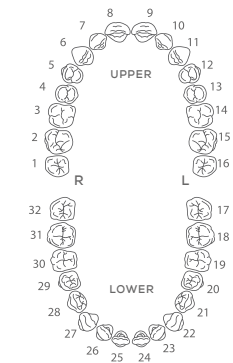
U L  
 Hard Splint  
 Brux-eze™ Splint  
 Rem-e-deze™ Splint  
 Gelb Splint  
 Comfort H/S™ Splint  
 Sports Guard  STRAP  NO STRAP  
 Bleaching Tray  
 Other \_\_\_\_\_

**PARTIAL DESIGN**  Lab Design Complete

MAJOR CONNECTORS	REST AREAS	TOOTH #
U L <input type="checkbox"/> Lab Select _____ <input type="checkbox"/> Palatal Strap _____ <input type="checkbox"/> Horseshoe _____ <input type="checkbox"/> Double Palatal Bar _____ <input type="checkbox"/> Lingual Bar _____ <input type="checkbox"/> Lingual Apron _____ <input type="checkbox"/> Double Bar _____	U L <input type="checkbox"/> Lab Select _____ <input type="checkbox"/> Mesial Rest _____ <input type="checkbox"/> Distal Rest _____ <input type="checkbox"/> Cingulum Rest _____ <input type="checkbox"/> Inverted V Rest _____ <input type="checkbox"/> Channel Rest _____	

SADDLE AREAS	TOOTH #	CLASP OPTIONS	TOOTH #
U L <input type="checkbox"/> Lab Select _____ <input type="checkbox"/> Mesh _____ <input type="checkbox"/> Mesh with Posts _____ <input type="checkbox"/> Metal Pads With Posts _____ <input type="checkbox"/> Open Face Dummy _____ <input type="checkbox"/> Metal Dummy _____ <input type="checkbox"/> Thermo Flex Dummy _____		U L <input type="checkbox"/> Lab Select _____ <input type="checkbox"/> Suprabulge _____ <input type="checkbox"/> Infrabulge (I-Bar) _____ <input type="checkbox"/> Flexible Tooth Shade _____ <input type="checkbox"/> Clear Cosmetic Clasp _____	

**INSTRUCTIONS**



**ACRYLIC SHADE**

Standard  Ethnic  
 Other  MILD  
 MODERATE  
 HEAVY

**DENTURE & TEETH**

**Shade** \_\_\_\_\_  
**Brand** \_\_\_\_\_  
**Mould** \_\_\_\_\_

**DR SIGNATURE** \_\_\_\_\_

DR LICENSE # \_\_\_\_\_

**For Warranty Information:** Please review the DSG Warranty Policy at [www.dentalservices.net/dsg-warranty](http://www.dentalservices.net/dsg-warranty)

**DO YOU NEED?**  Shipping Boxes  Shipping Labels **RXS:**  Standard  Fixed  Removable  Local (WHERE AVAILABLE)  
 Implant  Cosmetic  Ortho/Sleep  Value

**TERMS:** Net 15th of month. A finance charge of 1½% per month (18% annual) will be added to past due invoices F RR1 04