Rx Online REMOVABLE

Rx Date _____ Due Date _____

Dr _____

Address _____ Phone _____

City _____ Province _____

Try-In ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Finish ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Sex M ☐ F ☐

Patient's Name _____ Given Name _____ Age _____

MOULD & SHADE SPECIFICATIONS

Anteriors	Porcelain ☐	Plastic ☐	Shade _____	Mould _____	
Posteriors	Porcelain ☐	Plastic ☐	Shade _____	Mould _____	
	Rational ☐	Functional ☐	Twenty Degree (20°) ☐	Thirty-Three Degree (33°) ☐	

Brand of teeth to be used: _____

FACIAL CHARACTERISTICS

Check Basic Face Form

Square ☐ Square Tapering ☐ Tapering ☐ Ovoid ☐

Check Facial Asymmetry

Dominant Right Side ☐ Dominant Left Side ☐ Male ☐ Female ☐ Vigorous ☐ Soft ☐

SYSTEMS

ACRYLIC

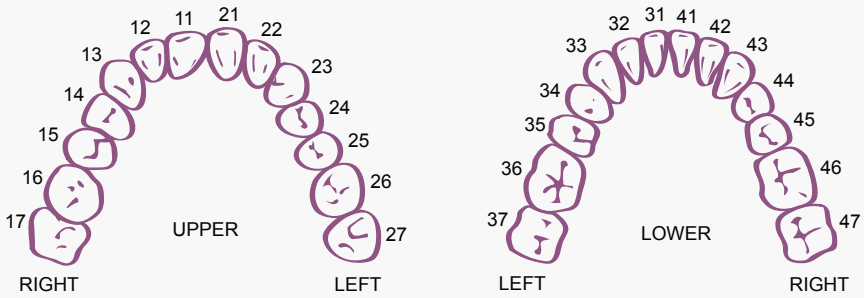
- ☐ PRIME DENTURESS (Dr. Carlson)
- ☐ BPS Ivocap
- ☐ LUCITONE 199
- ☐ VALPLAST
- ☐ THERMOFLEX
- ☐ FLEXITE
- ☐ ECLIPSE
- ☐ ENIGMA

METAL

- ☐ VITALLIUM 2000
- ☐ TITANIUM
- ☐ GOLD

SPECIAL TECHNIQUES & ATTACHMENTS	

DESIGN CASE



Rx

ITEMS ENCLOSED

	QTY
IMPRESSION / BITE	
RESTORATIONS(S)	
MODELS	
ARTICULATOR	
PHOTOS ATTACHED	

Dr's signature _____

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Toronto, Ontario
M4K 3Z1

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