PROSTHODONTIC DENTAL LAB

1006 Robertson Street, Fort Collins, CO 80524 Ph: 303-408-7106
271 South Downing Street, Denver, CO 80209 Ph: 720-365-9867
Fixed Laboratory : 720-219-6866

www.prosthodonticdentallab.com
info@prosthodeonticdentallab.com

Removable Prosthetic Rx

Laboratory Procedure Prescription

REQUIRED INFORMATION

Doctor Name _____
Last First

Practice Name _____

Address _____

Phone _____

Patient Name _____

Patient Chart #_____ ☐ M ☐ F DOB _____

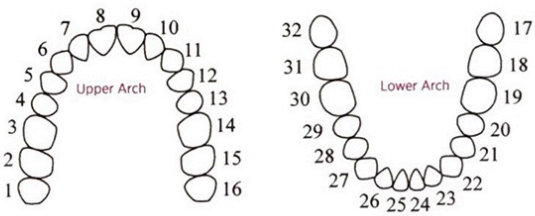
Rx Date _____ Due Date/Delivery on _____
(standard working time if no date given)

Case turnaround times are based on the date the Rx is received at PDL. Please allow 10 business days (M-F) from that date and 13 business days for complex cases.

PLEASE REFER TO OUR TIME SCHEDULE

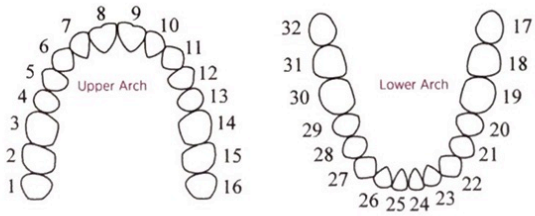
EXTRACTIONS

Please MARK all teeth to be extracted and replaced



CASE DESIGN

☐ Follow the doctor's design ☐ Best design for fit and function



Acrylic Shade (REQUIRED)

☐ **Lucitone 199*** ☐ Light Meharry

☐ Light Pink (Luc 199**L**) ☐ Meharry (Luc 199**D**)

Tooth shade_____ **Tooth Mould No.** _____
(REQUIRED)

Shade Guide Used _____ (Vita is default)

Standard design if an option is not selected

DENTURES

☐ Upper ☐ Lower

_____

☐ Custom tray ☐ Occlusal Rim

☐ **Set-up/Try-in*** ☐ **Denture*** ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

☐ Finish ☐ Patient ID (extra charge)

PARTIALS

☐ Upper ☐ Lower | ☐ **Set-up/Try-in*** ☐ Finish

☐ Custom Tray ☐ Occlusal Rim

Base Material (non-metal)

☐ **Acrylic Partial***
☐ CustomFlex™ Partial
☐ Valplast® Partial
☐ Immediate/Surgical partial

Metal Framework

☐ **Chrome Cobalt***
☐ Vitallium

☐ **Acrylic Partial**

NIGHTGUARDS/SPLINTS

☐ Upper ☐ Lower

☐ Soft
☐ Hard (clear acrylic)
☐ FlexiGuard™ (hard-soft)

OTHER

☐ Reline

☐ Soft Reline
☐ Rebase
☐ Simple repair
☐ Complex repair

RX SPECIFIC INSTRUCTIONS

Please provide any photos, study models, diagnostic casts with case
Email photos to: ddslabpix@ddslab.com

**The person signing this form is an authorized signer and, along with the dental practice, accepts responsibility for payment of all related charges, as well as any legal costs, collection and other fees incurred by DDS Lab in the event the account is sent to collections or litigation.

_____
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Dentist signature** (REQUIRED) _____

Dentist license no. (REQUIRED) _____

Please Send: ☐ Prescriptions ☐ Boxes ☐ Brochures