



www.edmondsdentalprosthetics.com

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FAX: 417.881.0484

SPECIAL INSTRUCTIONS

Please Call Please Text Phone: _____

Request Return Date: _____ Time: _____

Papillameter: High: _____ Low: _____

Alma Gauge: Vert: _____ Horiz: _____

Alameter: _____

DOCTOR INFORMATION

Date: _____

Dr. _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Patient: _____ Age: _____

Male Female

FULL DENTURE

Upper	Set-Up	Reset
Lower	Process	Custom Trays
Immediate	Bite Rim	Intraoral Tracer

DENTURE

Essential Premium

Add 3D Printed Backup Denture (\$199)

SHADE

Anterior: _____ Posterior: _____

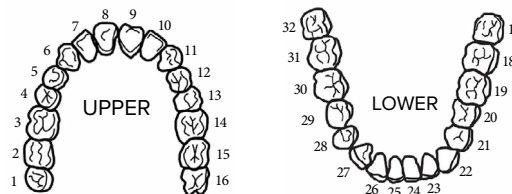
DENTURE BASE SHADE

Standard Light Ethnic Medium Ethnic Dark Ethnic

MISCELLANEOUS

Bleaching Trays

Occlusal Scheme: _____



ENCLOSED WITH CASE

Impression	Master Model	Bite Relation
Facebow	Attachment	Photos
Old Crown	Opposing Model	Articulator
Framework	Implant Components	

Other: _____

Has this case been disinfected? Yes No Digital Scan: _____

Date Sent: _____ Time Sent: _____

System: _____

PARTIAL DENTURE

CAST METAL

Nesbit Unilateral	Frame / Wax Rim
Frame Design Only	Frame / Teeth Processed
Frame Try-In	

REPLACING

Tooth #: _____ Shade: _____

CLASPING

Tooth #: _____ Shade: _____

Cast Wire Clear Pink

METAL FREE

Processed Acrylic	Flipper (Self-Cure)
Try-In	

REPLACING

Tooth #: _____ Shade: _____

CLASPING

Tooth #: _____ Shade: _____

Cast Wire Clear Pink

SERVICES

REPAIR

Base Tooth

RELINE

Hard Soft

ADD CLASP

Cast Wire

Tooth #: _____ Occlusal Scheme: _____

SIGN & COMPLETE PRESCRIPTION

Payment is due upon receipt of statement. Payment not received by the end of the following month is subject to a 1.5% per month service charge on the 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

PLEASE PRINT TWO COPIES OF COMPLETED SCRIPT. KEEP ONE FOR YOUR RECORDS AND SEND ONE WITH YOUR CASE