ROMADENT CERAMICS DENTAL LABORATORY

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Doctor: _____ **Date:** _____

Patient: _____ **Sex:** M F **Age:** _____

Finishing Date: _____ **Time Required:** _____ AM PM

PLEASE INDICATE CASE REQUIREMENTS BELOW

❑ COMPLETE DENTURE ❑ PARTIAL DENTURE ❑ CAST PARTIAL ❑ N.M. ORTHOTIC
___ FIXED
___ REMOVABLE

❑ MOUTH GUARD ❑ REPAIR ❑ RELINE ❑ SPLINT

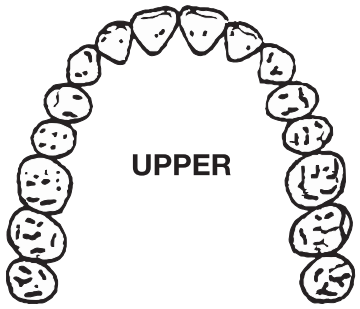
❑ PLEASE SEND BACK: ❑ FINISHED ❑ WAX TRY IN

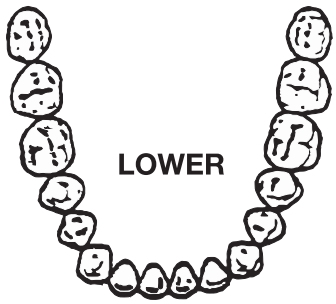
TEETH: ❑ ACRYLIC (PLASTIC) ❑ PORCELAIN

SHADE: _____ MOULD: _____

PALATAL RELIEF: ❑ YES ❑ NO

POST DAM: ❑ YES ❑ NO





ADDITIONAL INSTRUCTION:

HAVE YOU INCLUDED THE FOLLOWING:

- ❑ IMPRESSION
- ❑ BITE
- ❑ OPPOSING
- ❑ SHADE
- ❑ PRE-OP MODEL
- ❑ PHOTOS
- ❑ MODEL OF TEMPS

PLEASE SEND

- ❑ Fixed Rx's
- ❑ Removable Rx's
- ❑ Bags ❑ Boxes

FOR LAB USE

M _____
WX _____
P _____
G _____
PK _____
QC _____

DISINFECTED _____

Doctor's Signature _____