

DENTURES and PARTIALS

FROM _____ DATE _____

DR. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PH. 1-() _____

PATIENT'S NAME OR I.D. NO. _____

TYPE OF RESTORATION _____

FINISH TIME
AM
PM

DATE WANTED: TRY-IN _____ PM

Frame work only

Upper

Lower

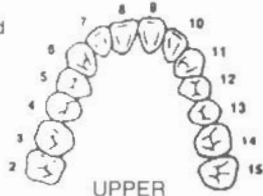
All cast metal

Metal Reinforced

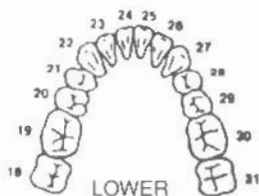
Horse shoe

Palatal bar

Dbl Palatal bar



UPPER



LOWER

FINISH

Light

Average

Heavy

Lingual Bar

Lingual Plate

D.E. Hinge

TEETH

Plastic

Porcelain

Shade _____

PFM Shade _____

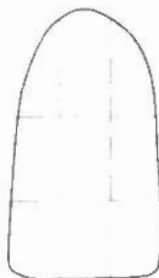
Other _____

CLASPS

Akers _____

Roach _____

I-bar _____



Special Instructions

AUTHORIZED SIGNATURE _____

LICENSE NO. _____ DATE _____

Dockstader

YOUR FULL SERVICE DENTAL LAB

340 WEST CROMWELL, SUITE 102 ■ FRESNO, CALIFORNIA 93711-6113

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