



Removable Prescription

DR: _____
STREET: _____
CITY: _____
STATE: _____ ZIP: _____
PHONE: (____) _____

CASE ENCLOSURES
Impressions
 Upper # _____
 Lower # _____
Models
 Upper # _____
 Lower # _____
Other
 Bite(s) # _____
 Photo(s) # _____
Emailed: photo@raglelab.com
 Pre-Op Model

PLEASE CALL
 Before proceeding
 To discuss restorative options

Note: Case is placed on hold until a response is received. Allow 1 day for call. Allow 2 days when model work needs completed prior to call.

DETERMINE DELIVERY DATE
*See time schedule
Requested Return Date: _____ / _____ / _____
DAY MO TIME
Patients Next Appointment: _____ / _____ / _____
DAY MO TIME

PATIENT INFORMATION:
(LAST): _____
(FIRST): _____
AGE: _____ MALE FEMALE

PLEASE SEND
 Prescriptions
 Large Boxes
 Small Boxes
 Safety Bags
 Other _____

TEETH
 Ivoclar BlueLine
 Portrait IPN
 Bioform IPN
 Substitute Economy Tooth (Lab Choice)
 Other: _____

Shade _____
Mould _____
Papillameter _____
Alameter _____
Desired Overbite _____ mm
Desired Overjet _____ mm

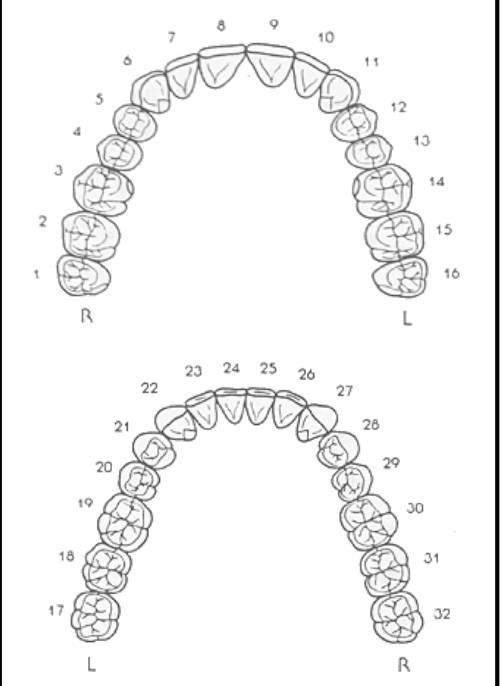
NIGHT GUARD
 Acrylic
 Soft (Mouth Guard)
 Proform Mouth Guard
 Color _____
 Bleaching Tray
 Scallop

ACRYLIC PARTIAL/FLIPPER
 Upper
 Lower
 Wire Clasp
 Ball Clasp
 Thermo-Flex
CLASPS
 Tooth colored—shade _____
 Pink Color

ACRYLIC SHADE
 Lucitone 199 Hi-Impact
 1/2 Dark Dark

SET-UP PREFERENCE
 Ideal Characterized
 Follow Study Model

REPAIR
 Relines Hard Soft
FULL DENTURE
 Upper Lower Immediate
 Set Teeth Re-Set Finish
METAL PARTIAL FRAMEWORK
 Upper Lower Design
 Bite Rim Lab Design
 Set Teeth Finish
 Equipoise Rests for #s _____
 Natural Clasps for #s _____



ADDITIONAL INSTRUCTIONS:

Signature of Dentist Required _____ Dentist License # _____

DENTURES & PARTIALS

