

REMOVABLE PROSTHESIS LABORATORY



Clinic:	Dentist:
Email	Phone:
Date sent:	Address:

Patient name:	Conventional <input type="checkbox"/> Digital <input type="checkbox"/>	Due Date:
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PROSTHESIS TYPE

☐ Complete Acrylic Dentures
☐ Partial Acrylic Dentures
☐ Immediate Dentures
☐ Night guard
☐ Whitening tray
☐ Essix retainers
☐ Special tray

DENTURES

☐ Upper arch
☐ Lower arch
☐ Upper + Lower arch
☐ Repair
☐ Addition
☐ Soft Reline
☐ Hard Reline

Case no:

Provisional: ☐

Continuation: ☐

Remake: ☐

Thickness of night guard/retainer:

Colour required:

TOOTH NUMBER

1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8
4.8	4.7	4.6	4.5	4.4	4.3	4.2	4.1	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8

Proximal contacts: Standard ☐ Broad ☐ Point ☐

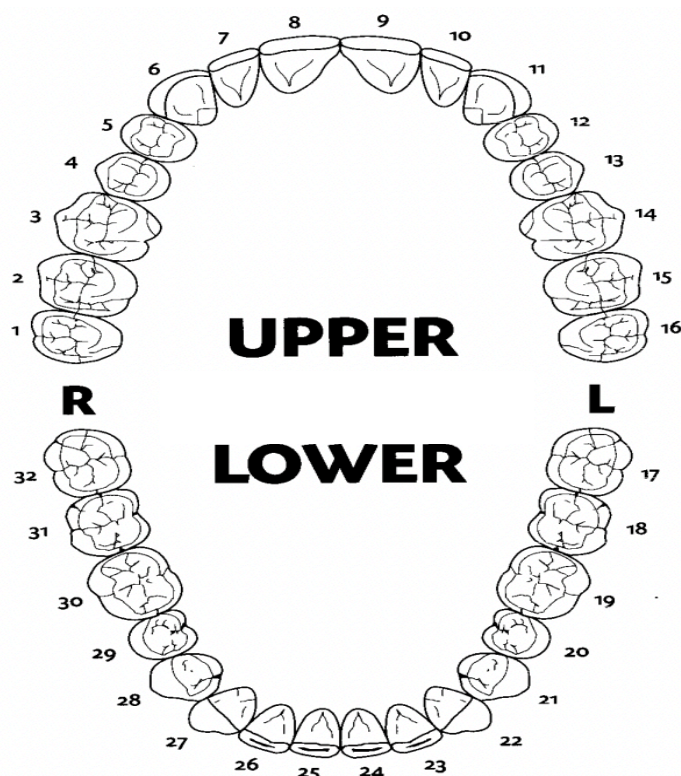
Occlusal contacts: Standard ☐ Open ☐ Light ☐

Provided: Digital photos ☐ STL scans ☐ Upper/lower Impression ☐ Wax Rim ☐ Bite registration ☐ Waxup ☐

Required: Wax Rim ☐ Framework ☐ Tooth setup ☐

Tooth shape: Rectangular ☐ Square ☐ Triangular ☐ Ovoid ☐

Additional details:
 (Please draw and describe the desired details of the prosthesis using the diagrams and the text box below)
 Example; clasps for dentures, night guard thickness, smile line of patient, midline.



Please provide form via email or hand in at delivery.
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