MICRODENTAL
a dti laboratory
DUBLIN · CALIFORNIA

5601 Arnold Road · Dublin, CA · 94568
P 800 229 0936 · F 925 828 0153

# Removable Prosthetics & Orthodontics Rx

**ATTN:** _____ **ACCOUNT#:** _____

**RX Date** _____ **Due Date** _____

**NOTE:** If no due date is assigned, a standard MicroDental due date will be applied.

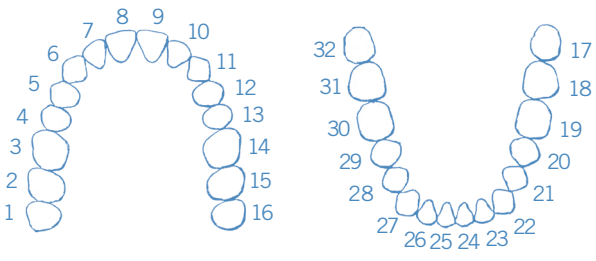
DR. NAME/ADDRESS _____ PATIENT NAME _____

DR. PHONE _____ SEX: M/F AGE: _____

SIGNATURE OF DENTIST _____ DENTIST LICENSE# _____

Person signing this authorization accepts sole responsibility for payment and agrees to pay all legal and collection costs in the event of suit, including reasonable fees.

❍Framework Try-In ❍Framework/Teeth Try-In ❍Spot Opposing
❍Wax Bite on Frame ❍Finish




UPPER ARCH LOWER ARCH

YOUR DESIGN

**ANTERIOR TEETH**
Brand_____ Mold_____ Shade_____

**POSTERIOR TEETH**
Brand_____ Mold_____ Shade_____

**PAPILLAMETER READING** _____mm
(InteliDent)

**ALAMETER READING** _____mm
(InteliDent)

**SHADE** _____

**SMILE TYPE**
❍Vigorous
❍Soft
❍Natural

**ACRYLIC**
❍Heat Cure
❍Pink
❍Clear

**PLEASE SEND**
❍Rx's
❍FedEx Airbills
❍UPS Airbills
❍Boxes

**FOR LAB USE ONLY**

## REMOVABLES

**CASE DESIGN & CONSTRUCTION**
❍Lab Select-Complete Design

**METAL**
❍Perfect Partial Vitallium 2000+
❍Flat Rate Partial Vitallium 2000 (Classic Teeth only)
❍Gold
❍Combination Metal w/Resin

**METAL-FREE**
❍Valplast®
❍FRS
❍Dental-D™

**CLASPING (Please fill in tooth # when applicable)**
❍Akers/Location_____
❍Ring/Location_____
❍I Bar/Location_____
❍T-Bar/Location_____
❍Modified T-Bar/Location_____
❍Valplast Clasp
❍Dental-D Clasp

**TEMPORARIES**
❍MicroTemp™
❍Cast Metal Reinforcement

**PROSTHETIC TYPE**
❍Perfect Denture
❍Flat Rate Denture (Classic Teeth only)
❍InteliDent™
❍Immediate Denture
❍Stay Plate
❍Custom Tray
❍Bite Rims
❍Guidance Rims (InteliDent)
❍Gingivamoll®
❍Soft Reline

## ORTHODONTICS

**FIXED APPLIANCES**
(Soldered to your bands)
❍Lingual Arch
❒ 3-3
❒ 6-6
❍Rapid Palatal Expansion
❒ Hygienic
❒ Haas
❒ Bonded
❍Habit Device

| ARCH EXPANDERS | UPPER | LOWER |
|---|---|---|
| Sagittal | ❍ | ❍ |
| Schwarz | ❍ | ❍ |

| HAWLEY ORTHO | UPPER | LOWER |
|---|---|---|
| Standard Design (Labial bow plus 1 set of clasps) | ❍ | ❍ |
| Wrap Around Design (0.20 support wires/no clasps) | ❍ | ❍ |
| Labial Bow Soldered to clasps | ❍ | ❍ |

| SPRING RETAINERS | UPPER | LOWER |
|---|---|---|
| 3x3 Cuspid to Cuspid | ❍ | ❍ |
| 4x4 Bicuspid to Bicuspid | ❍ | ❍ |

| SPLINTS | UPPER | LOWER |
|---|---|---|
| Mora (Gelb) | ❍ | ❍ |
| BruxiGuard™ Soft (Vacu-Formed) | ❍ | ❍ |
| BruxiGuard Hard/Soft (Vacu-Formed) | ❍ | ❍ |
| BruxiGuard Hard (Heat-Cured) | ❍ | ❍ |
| BruxiGuard Combo. (Hard/Thermoplastic) | ❍ | ❍ |

**SPLINT OPTIONS**
❍Indentations of opposing arch
❍Cuspid rise
❍Grind in

| ORTHO MISCELLANEOUS | UPPER | LOWER |
|---|---|---|
| Implant Stent | ❍ | ❍ |
| Palatal Stent | ❍ | ❍ |
| Bleaching Tray | ❍ | ❍ |
| ActionGuard™ | ❍ | ❍ |
| Single-Layered | ❍ | |
| Double-Layered | ❍ | |
| Triple-Layered | ❍ | |

## INSTRUCTIONS

❍ **CALL ME (BEFORE PROCEEDING WITH CASE)**

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**800 229 0936 · Fax 925 828 0153**

WHITE-LAB COPY
PINK-DOCTOR COPY

NOTE: Retain pink sheet for your records and return white sheet with work to be completed. Please use blue or black ink when completing this form.
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