[Case No. _____]

Dental Art Solution

DENTAL LAB, INC.

dentalartsolution@gmail.com
800-592-7304

Rx Date :
Date Due in Office :
(Deliver By 5PM)

Doctor's Name (Please Print) _____

Doctor's Address _____

Patient's Name _____ ☐ M ☐ F Sex _____ Age _____

REMOVABLE RESTORATIONS (Please ☑)

Dentures

- ❒ Custom Tray
- ❒ Base Plate/Wax Rim
- ❒ Deluxe Denture
- ❒ Immediate Denture
- ❒ Denture Set-Up
- ❒ Denture Finish

Repairs / Relines

Relines

❒ Hard ❒ Soft

Repairs

❒ Tooth ❒ Fractures
❒ Clasp

Specialty Products

- ❒ Deluxe Guard
- ❒ Bleaching Tray

Metal Partials

- ❒ Deluxe Partial (Vitallium 2000)
- ❒ Frame Try-In
- ❒ Wax Try-In with Teeth
- ❒ Bite Block
- ❒ Finish

Flexible Partials

- ❒ DuraFlex™ (Valplast®)
- ❒ Set-Up
- ❒ Finish

Premium Products

- ❒ Ivocap Injection System

Specialty Partials

- ❒ Acrylic Partial Flipper
- ❒ Acrylic Partial w/ Clasp
- ❒ Metal / Acrylic

Shade

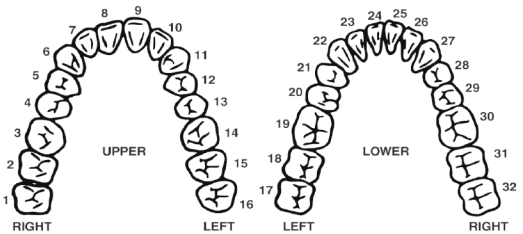
Acrylic	*Flexible*
❒ Light Pink	❒ Pink
❒ Original	❒ Meharry
❒ Dark	
❒ Other (_____)	

Tooth Shade _____

Tooth Mold _____

Tooth Make _____

℞ **SPECIFIC INSTRUCTIONS :**



Doctor's Signature _____ Lic. # _____