DENTAL CERAMICS, INC.
3404 Brecksville Road • Richfield, OH 44286 • 330-523-5240 / 1-800-647-8748
Excellence in Clinical Communication

Removable Prescription

Date _____

Dr. _____

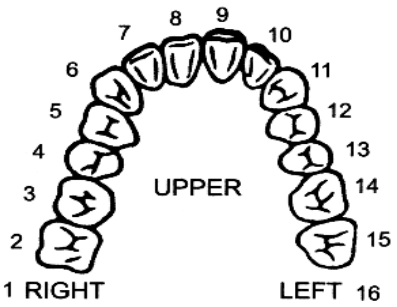
Pt. _____

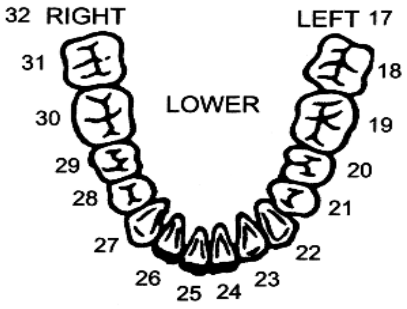
Age _____ Male / Female

Date Required _____

ITEMS RECEIVED

- ____ Implant Parts
- ____ Impression
- ____ Base Model
- ____ Opposing Model
- ____ Bite
- ____ Study Model
- ____ Partial
- ____ Denture
- ____ Set-Up
- ____ Photos
- ____ Teeth
- ____ Other





REQUEST CALL AFTER MOUNTING? ☐ **YES** ☐ **NO**

PLEASE CHECK DESIRED MOUNTING

☐ FOX PLANE ☐ STRATOS
☐ STICK BITE ☐ OTHER_____

FACIAL CHARACTERISTICS

☐ MALE ☐ FEMALE
☐ VIGOROUS ☐ SOFT

Anterior Mould: Upper_____ Lower_____ Shade_____
Posterior Mould: Upper_____ Lower_____ Shade_____

DENTURE BASE

☐ "IVOCAP" INJECTION
☐ GINGIVAL TINTING

SHADE (Circle One)
US-P US-D US-L
PREFERENCE

A-D SHADES

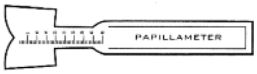
ANTERIOR	POSTERIOR
PHONARES®	PHONARES® TYP 22°
BLUELINE® DCL	PHONARES® LINGUAL 15°
	ORTHOPLANE® DCL 0°
	ORTHOLINGUAL® DCL 15°
	ORTHOTYP® 22°
	POSTARIS 33°

☐ OCCLUSAL RIMS
☐ CUSTOM TRAY
☐ SET-UP
☐ FINISH
☐ RELINE
☐ REPAIR

☐ ACRYLIC PARTIAL
☐ FLIPPER
☐ OVERDENTURE
☐ ESSIX RETAINER
☐ BLEACHING TRAY
☐ OTHER_____

☐ VITALLIUM® 2000
☐ DC FLEXIBLE PARTIAL
☐ RESIN CLASPS
☐ FACING
☐ HIDDEN CLASPS
☐ LASER WELD/ADDITION

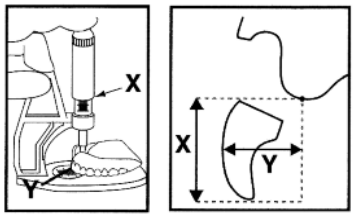
Papillameter



High Lip Line_____mm

Low Lip Line _____mm

Denture Gauge



Y = _____mm

X = _____mm

SPECIAL INSTRUCTIONS:

Dr. Signature _____

License Number _____

Address _____

Telephone _____