



19155 S.E. MCLOUGHLIN BLVD.  
 SUITE 105  
 GLADSTONE, OREGON 97027  
**(503) 656-2775**  
**FAX (503) 656-2120**  
**1-800-595-3495**

**CUSTOM DENTAL PROSTHETICS, INC**

FROM \_\_\_\_\_ DATE \_\_\_\_\_

DOCTOR \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE#( \_\_\_\_\_ ) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

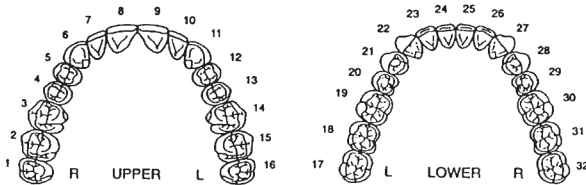
PATIENT'S NAME \_\_\_\_\_  
Last Name First Name

<input type="checkbox"/> DELICATE	AGE	SEX	SHADE	MOULD
<input type="checkbox"/> MEDIUM				
<input type="checkbox"/> VIGOROUS				

DATE WANTED	TIME	AM
		PM

<input type="checkbox"/> Try In	<input type="checkbox"/> Finish	<input type="checkbox"/> Custom Tray	<input type="checkbox"/> Occlusion Rim
<b>CHECKLIST</b>		<b>ANTERIOR SET-UP</b>	
<input type="checkbox"/> Midline Marked		<input type="checkbox"/> Ideal	
<input type="checkbox"/> High Lip Line - Marked		<input type="checkbox"/> Characterized	
<input type="checkbox"/> Proper Lip Support		<input type="checkbox"/> Study Model	

**Rx SPECIFIC INSTRUCTIONS:**



SIGNATURE \_\_\_\_\_

LICENSE NUMBER \_\_\_\_\_

*Bills are due and payable by the 10th of the month following billing. All bills not paid in full within 30 days following month of billing will carry a 1 1/2% per month service charge.*