MAIL ON ______________________________

CUSTOM DENTAL PROSTHETICS, INC

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

FROM DATE ______________________

DOCTOR ____

ADDRESS ____ PHONE#(_____) ______________

CITY _______________________________________ STATE______________ ZIP ______________

PATIENT'S NAME ______________________________, ____________________________________
Last Name First Name

☐ DELICATE ☐ MEDIUM ☐ VIGOROUS	AGE	SEX	SHADE	MOULD

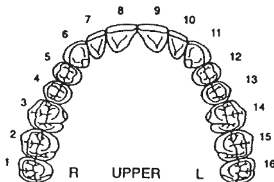
DATE WANTED	TIME	AM PM

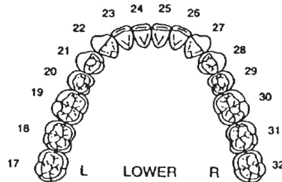
☐ Try In ☐ Finish ☐ Custom Tray ☐ Occlusion Rim

CHECKLIST
- ☐ Midline Marked
- ☐ High Lip Line - Marked
- ☐ Proper Lip Support

ANTERIOR SET-UP
- ☐ Ideal
- ☐ Characterized
- ☐ 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.