

6829 Ashen Lane | 512-897-4772
 Austin, TX 78747 | help@southaustindentallab.com

REQUIRED INFORMATION

Rx Date: _____ Due Date/Delivery By: _____

Doctor Name: _____

Practice Name: _____

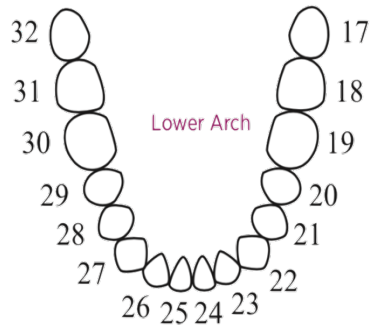
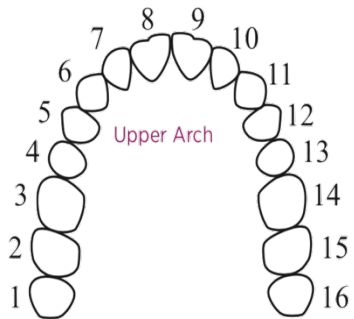
Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Patient Name: _____

Patient Age: _____ Patient Sex: M F



REMOVABLE RESTORATIONS

Please check all that apply.

DENTURES		FLEXIBLE PARTIAL		COMPLEMENTS	
<input type="checkbox"/>	Custom Tray	<input type="checkbox"/>	TCS Unilateral	<input type="checkbox"/>	Clasp Clear
<input type="checkbox"/>	Bite Block	<input type="checkbox"/>	TCS Partial	<input type="checkbox"/>	Clasp Ball, C or Y
<input type="checkbox"/>	Denture Set-up Full	<input type="checkbox"/>	Combo w/ Metal Flexible	<input type="checkbox"/>	Wire Mesh
<input type="checkbox"/>	Process & Finish	REPAIRS		DENTAL APPLIANCE	
<input type="checkbox"/>	Complete Full Denture	<input type="checkbox"/>	Acrylic Fracture/Repair	<input type="checkbox"/>	Hard Acrylic Night Guard
<input type="checkbox"/>	Immediate Full Denture	<input type="checkbox"/>	Add Tooth to Denture	<input type="checkbox"/>	Thermo Plastic Night Guard
<input type="checkbox"/>	Full Denture Reset	<input type="checkbox"/>	Reline	SHADING	
<input type="checkbox"/>	Soft Denture	<input type="checkbox"/>	Rebase	<input type="checkbox"/>	Pink <input type="checkbox"/> Dark
<input type="checkbox"/>	Flipper 1 or 2 Teeth	CAST FRAME PARTIAL		<input type="checkbox"/>	Meharry
<input type="checkbox"/>	Partial Denture	<input type="checkbox"/>	Metal Frame	Tooth Shade _____	
<input type="checkbox"/>	Soft Gasket Retention	<input type="checkbox"/>	Rebase	<input type="checkbox"/>	Check for Rush Processing

Rx SPECIFIC INSTRUCTIONS

Doctor's Signature: _____ License # _____