



1805 LOUCKS RD SUITE 300 YORK, PA 17408  
 Phone: 888-776-5229 Fax: 717-356-2525

Your Reference # \_\_\_\_\_

Doctor \_\_\_\_\_

Patient Name \_\_\_\_\_

Date Sent \_\_\_\_\_ Due Date \_\_\_\_\_

Promo Code: FREEREMOVABLE  
 Free Flex Partial or Single Arch Denture

**PARTIAL DENTURES**

PARTIALS WITH FRAMES

- CoCr     Vitallium
- FRAME ONLY
- FRAME BITE BLOCK/RIM
- FRAME W/TEETH SET UP
- FRAME/SETUP/FINISH
- RESET TEETH ONLY
- PROCESSING

TYPE OF ACRYLIC

- CONVENTIONAL
- LUCITONE 199
- VALPLAST

PARTIALS ALL ACRYLIC

- TEETH SET UP FINISH ALL ACRYLIC
- WAX TRY-IN ALL ACRYLIC
- PROCESSING ALL ACRYLIC
- ADD TOOTH ALL ACRYLIC
- RESET TEETH ALL ACRYLIC

TYPE OF ACRYLIC (FLEXIBLE)

- CONVENTIONAL
- LUCITONE 199
- VALPLAST
- TCS
- DURAFLEX

OTHER

- ADD TOOTH(2916)  
# \_\_\_\_\_
- ADD WIRE CLASP  
# \_\_\_\_\_
- ADD CAST CLASP  
# \_\_\_\_\_
- VALPLAST CLASP  
# \_\_\_\_\_
- CLEAR CLASP  
# \_\_\_\_\_

**Items Sent: (Circle all that apply)**

- |                                      |   |                                      |
|--------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Single Tray | <input type="checkbox"/> Triple Tray    | <input type="checkbox"/> Study Model |
| <input type="checkbox"/> Upper Model | <input type="checkbox"/> Lower Model    | <input type="checkbox"/> Bite Block  |
| <input type="checkbox"/> Bite        | <input type="checkbox"/> Wax with Teeth | <input type="checkbox"/> Articulator |
| <input type="checkbox"/> Frame       |   |                                      |

Other \_\_\_\_\_

**FRAMEWORK DESIGN**

- LAB TO DESIGN
- SEE DRAWING ON RX
- SEE DRAWING ON CAST

**TOOTH SHADE**

**ACRYLIC SHADE**

- MESIAL REST(S) ON \_\_\_\_\_
- DISTAL REST(S) ON \_\_\_\_\_
- CINGULUM REST(S) ON \_\_\_\_\_

**FULL DENTURES**

FULL DENTURES

- SET TEETH TRYIN (2012)
- PROCESSING (2013)
- SET TEETH & PROCESS (2011)
- SET TEETH & PROCESS(2014)  
W/Lucitone 199
- PROCESS W/LUCITONE(2015)  
W/Lucitone 199
- TCS SUCTION CUP

IMMEDIATE DENTURES  
*(Extract All Teeth)*

- IMMEDIATE TEETH SET UP FINISH (2151)
- IMMEDIATE WAX TRY-IN (2152)

TYPE OF ACRYLIC

- CONVENTIONAL     LUCITONE 199

OTHER

- OCCLUSAL SPLINT(2918)
- SURGICAL STENT(2919)
- BLEACHING TRAY(2923)
- CUSTOM IMPRESSION TRAY(2924)
- DUPLICATE MODEL(2935)
- RESET TEETH
- NESBIT DIRECT FINISH(2131)
- ACRYLIC FLIPPER(2171)
- SPACE MAINTAINER(2909)
- BASE PLATE/BITE RIM(2911)
- NIGHT GUARD SOFT(2921)
- NIGHT GUARD HARD(2922)

**REMAKE INFORMATION**

(Please complete this section if returning this case for a remake)

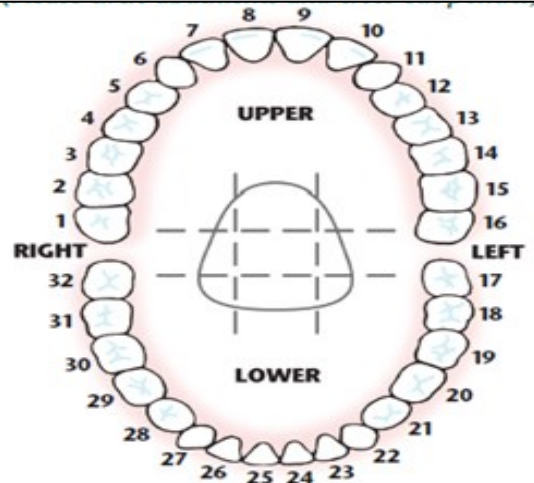
Customer Original Pan # \_\_\_\_\_ PLS Original RX # \_\_\_\_\_

Reason for Remake \_\_\_\_\_

**Items being Returned**

- Original Prosthesis ( Partial, Bite, Etc.)
- Original Model                      Original Die                      Original PLS RX
- Old Impression                      New Impression                      Study Model

*(Failure to provide original RX, reason, or items may result in a delay in processing this case and a charge for this remake)*



**SELECT WORK TO BE MADE**

UPPER                      LOWER

**OTHER SPECIAL INSTRUCTIONS**



# Customer Information Sheet

Comment/Special instructions

## Customer Information

Full Name of Lab:

Email:

Address:

*Street Address*

*Unit #*

*City*

*State*

*ZIP Code*

Business Phone: \_\_\_\_\_

Cell Phone  
\_\_\_\_\_

Website: \_\_\_\_\_

Bill to address:

[if different from above]:

## Shipping Address

[if different from above]:

Address:

*Street Address*

*Unit #*

*City*

*State*

*ZIP Code*

Business Phone: \_\_\_\_\_

## Key Contact

Technical Contact

*Title*

*Phone*

*Email*

Accounting Contact

*Title*

*Phone*

*Email*

Alternate Contact

*Title*

*Phone*

*Email*

## General Information [please answer all questions]

Briefly describe company/agency's primary endeavors: \_\_\_\_\_

How did you first hear about us? \_\_\_\_\_

