Sallee DENTAL STUDIO

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(812) 332-6277 or (812) 332-6314
Email: info@salleedental.com

Dr. _____	Date _____
Date Sent _____	Due Date _____
Patient _____	Age _____ M _____ F _____
Due Date _____	Shade _____

Removables

Complete Denture: ☐ Upper ☐ Lower

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Portrait / Blueline: ☐ **Image APN:** ☐ **Iterim:** ☐

Partial Denture: ☐ Acrylic ☐ Flexible ☐ Metal Framework

Night Guard: ☐ Hard ☐ Soft

Custom Impression Tray: ☐

Bite Rim: ☐ **Bite Block:** ☐

Relines/Rebase: ☐ Hard Reline ☐ Soft Reline ☐ Rebase

Shade Information

Tooth Shade _____ Tissue Shade _____ Shade Guide Used _____

Tooth Setup

☐ Male ☐ Female Age _____ Face Shape _____

Anterior Mould _____ Posterior Mould _____ ☐ 33° ☐ 22° ☐ 20° ☐ 10° ☐ 0°

Immediates

Tooth # Extracted _____ ☐ Socketed ☐ Flush at Gingival

☐ Cast Palatal Mesh Reinforced ☐ Cast Implant Strength Bar

Additional Instructions:

Doctor Signature: _____

License Number: _____

Thank you,

Jason Hamilton, CDT