

Functional Prosthetics

Dental Laboratory LLC

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318-218-6293

Doctor _____
(please print)

Patient _____

Male

Female

_____ Patients age

REMOVABLE SCHEDULE	
DATE WRITTEN	/ /
DATE NEEDED	/ /
TIME PATIENT APPOINTED	:
	<input type="checkbox"/> AM <input type="checkbox"/> PM

Shade _____ Mould _____

Denture Base Material

- Diamond D
- Microfit VR-90 (vinyl)
- Molly B Soft Liner

Acrylic Shade

- Pink
- Light Reddish Pink
- Clear
- Ethnic

Tooth Material

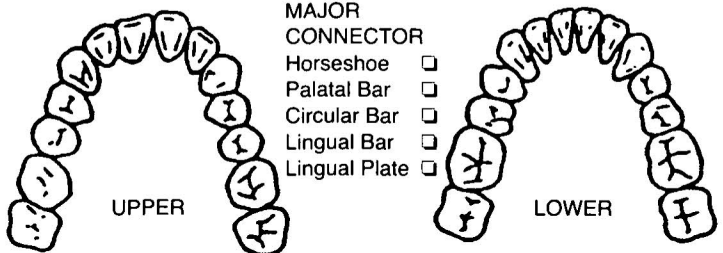
- Porcelain
- Plastic
- Cutters

Partials

- Vitalium 2000
- Chrome Cobalt
- High Noble (yellow)
- Acrylic with wire

Please Fill Out

- Custom Trays
- Wax Bite
- Wax Try in
- Insert



Dentist Signature _____ Lic. No. _____