# Partial Denture Rx

(434) 282-4862 or admin@paramountdentalstudio.com

PARAMOUNT
DENTAL
STUDIO

1. Patient _____
2. Gender ☐ Male / ☐ Female
3. Age _____

4. Doctor _____
5. License No _____
6. Phone _____
7. Date sent ____ / ____ / _____

## 8. Restorative arch(es)

**UPPER ARCH**
☐ **Teeth** #s _____
    ☐ This is an immediate denture
    ☐ Teeth #s to be extracted
      #s _____
☐ **Flexible partial**
    ☐ **TCS** (Lab default)
    ☐ **Valplast**
☐ **Acrylic partial**
    ☐ **Partial denture**
    ☐ **Flipper**
☐ **Metal partial**
    ☐ **Metal partial** (CoCr)
    ☐ **Metal framework only** (CoCr)

**LOWER ARCH**
☐ **Teeth** #s _____
    ☐ This is an immediate denture
    ☐ Teeth #s to be extracted
      #s _____
☐ **Flexible partial**
    ☐ **TCS** (Lab default)
    ☐ **Valplast**
☐ **Acrylic partial**
    ☐ **Partial denture**
    ☐ **Flipper**
☐ **Metal partial**
    ☐ **Metal partial** (CoCr)
    ☐ **Metal framework only** (CoCr)

## 9. Items for next appointment

☐ **Wax bite rim(s)**
☐ **Try-in(s)**
    (Traditional wax
    try-ins with teeth)
☐ **Final(s)**

## 10. Additional features

☐ **Flexible clasps** #s _____
    ☐ **Clear clasps** #s _____
☐ **Wire Clasps** #s _____
☐ **Metal mesh**
☐ **Name in denture**

PLEASE ANSWER QUESTIONS 11–12 AT YOUR EARLIEST OPPORTUNITY.
WE NEED THESE ANSWERS TO MAKE WAX TRY INS AND FINALS:

## 11. Tooth shade

Tooth shade _____
    (only Vita Classical shades)

## 12. Tissue shade

☐ **Light pink**
☐ **Original/Standard pink**
(Lab default)
☐ **Dark pink**

## 13. Additional Notes

_____
_____
_____
_____