1010 S. 24th St. W.
Billings, Montana 59102
PHONE (406)651-8603
FAX (406) 651-8633
Email: pdlpix@gmail.com

DOCTOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENTS NAME: _____

AGE: _____ MALE ☐ FEMALE ☐

DATE STARTED: _____ / _____ / _____

RETURN DATE: _____ / _____ / _____

CUSTOM TRAY:
MAXILLARY ☐
MANDIBULAR ☐

BASE PLATE/OCCLUSAL RIM:
MAXILLARY ☐
MANDIBULAR ☐

FULL DENTURE:
MAXILLARY ☐
MANDIBULAR ☐

IMMEDIATE DENTURE:
MAXILLARY ☐
MANDIBULAR ☐

CAST PARTIAL:
MAXILLARY ☐
MANDIBULAR ☐

WROUGHT PARTIAL:
MAXILLARY ☐
MANDIBULAR ☐

FLIPPER:
MAXILLARY ☐
MANDIBULAR ☐

RELINE: (HARD OR SOFT)
MAXILLARY ☐
MANDIBULAR ☐

TMJ SPLINT:
MAXILLARY ☐
MANDIBULAR ☐

REPAIR:
MAXILLARY ☐
MANDIBULAR ☐

FULL ARCH SET-UP:
MAXILLARY ☐
MANDIBULAR ☐

PARTIAL SET-UP:
MAXILLARY ☐
MANDIBULAR ☐

VALPLAST:
MAXILLARY ☐
MANDIBULAR ☐

(CIRCLE ONE)
TEETH: PLASTIC PORCELAIN

POSTERIOR DEGREE: 0* 10* 20* 30* 33*

SHADE _____ MOLD _____

SPECIAL INSTRUCTIONS:

Midline -

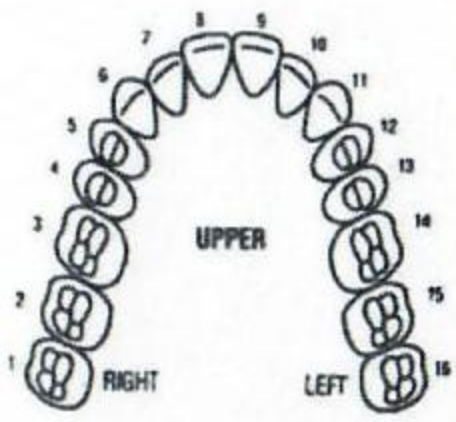
Incisal Length -

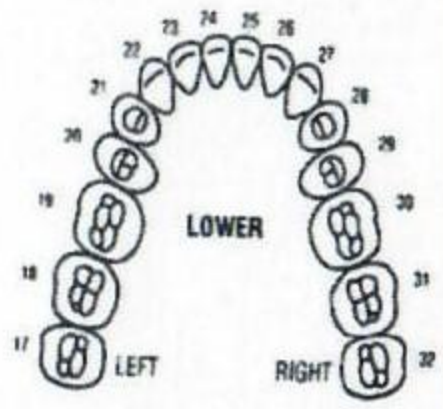
Horizontal -

Angulation -

Labial Profile -

Free Way Space -





SIGNATURE: _____ **LICENSE NO.** _____

For Office Use Only	Articulation ☐	Pour/Trim U: ☐ L: ☐	Re-Articulate ☐	Base Model U: ☐ L: ☐