

"Practicing team dentistry of tomorrow...today."



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Email: gary@liberty-dental.com

Website: www.liberty-dental.com

REMOVABLE RESTORATION Rx

Your license # _____

Dr. _____

Patient name _____

Date sent _____ Due date _____

Barcode:

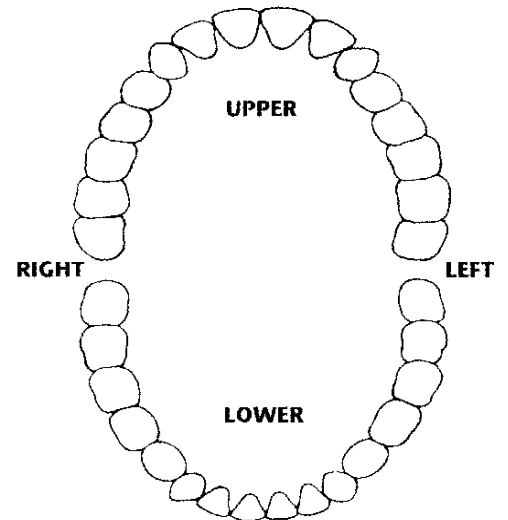
TYPE OF RESTORATION

- | | | |
|--|---|---|
| <input type="checkbox"/> Metal Frame Denture | <input type="checkbox"/> Rebase / Reline | <input type="checkbox"/> Custom Tray |
| <input type="checkbox"/> Acrylic Denture | <input type="checkbox"/> Add Clasp on # _____ | <input type="checkbox"/> Perforated |
| <input type="checkbox"/> Complete | <input type="checkbox"/> Add Tooth on # _____ | <input type="checkbox"/> Non-Perforated |
| <input type="checkbox"/> Partial | <input type="checkbox"/> Bleaching Tray | <input type="checkbox"/> Night Guard |
| <input type="checkbox"/> Immediate partial | | <input type="checkbox"/> Soft |
| | | <input type="checkbox"/> Hard |

FRAMEWORK DESIGN

- Lab to Design
 See Drawing on Rx
 See Drawing on Cast

(Please draw your design here)



ARCH

- Upper Lower Upper & Lower

METAL

- CoCr
 Vitallium 2000

ACRYLIC

- Conventional
 Lucitone 199
 Valplast

SERVICE DESIRED

- | | |
|--|--|
| <input type="checkbox"/> Direct Finish | <input type="checkbox"/> Acrylic Denture Try-In |
| <input type="checkbox"/> Metal frame Denture Try-In | <input type="checkbox"/> Base Plate + Bite Rim / Rack |
| <input type="checkbox"/> Metal Frame Only | <input type="checkbox"/> Base Plate + Teeth Set Up |
| <input type="checkbox"/> Metal Frame + Bite Block (s) | <input type="checkbox"/> Teeth Set Up Only |
| <input type="checkbox"/> Metal Frame + Teeth Set Up | <input type="checkbox"/> Acrylic Processing Only |
| <input type="checkbox"/> Teeth Set Up Only | <input type="checkbox"/> Teeth Set Up + Acrylic Processing |
| <input type="checkbox"/> Teeth Set Up + Acrylic Processing | <input type="checkbox"/> Acrylic Processing Only |
| <input type="checkbox"/> Acrylic Processing Only | |

REST

- Mesial Rest on # _____
 Distal Rest on # _____
 Cingulum Rest on # _____

OTHER SPECIAL INSTRUCTIONS

SHADE _____

MOULD _____

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FIXED RESTORATION Rx

Your license # _____

Dr. _____

Patient name _____

Date sent _____ Due date _____

Barcode: _____

TYPE OF RESTORATION

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> PFM | <input type="checkbox"/> Full Cast | <input type="checkbox"/> All Ceramic |
| <input type="checkbox"/> Non-Precious | <input type="checkbox"/> Non-Precious | <input type="checkbox"/> Procera |
| <input type="checkbox"/> Semi-Precious | <input type="checkbox"/> Semi-Precious | <input type="checkbox"/> Cercon |
| <input type="checkbox"/> Gold 86% | <input type="checkbox"/> Precious | <input type="checkbox"/> Empress |
| <input type="checkbox"/> Captek | <input type="checkbox"/> Gold | <input type="checkbox"/> Wolceram |
| <input type="checkbox"/> Soft | <input type="checkbox"/> 40% <input type="checkbox"/> 63% <input type="checkbox"/> 74% | <input type="checkbox"/> Soft |

SERVICE DESIRED

- | | | |
|--|--|---|
| <input type="checkbox"/> Single Unit Crown | <input type="checkbox"/> Veneer | <input type="checkbox"/> Direct Finish |
| <input type="checkbox"/> Splinted Crowns | <input type="checkbox"/> Inlay / Onlay | <input type="checkbox"/> Metal Try-In |
| <input type="checkbox"/> Bridge | <input type="checkbox"/> Post and Core | <input type="checkbox"/> Apply Porcelain Only |
| <input type="checkbox"/> Maryland Bridge | <input type="checkbox"/> Post Crown | <input type="checkbox"/> Temp Crown |

METAL DESIGN

- | | |
|---|---|
| <input type="checkbox"/> No Metal to Show | <input type="checkbox"/> Metal Occlusal—Posterior |
| <input type="checkbox"/> Buccal Collar _____mm | <input type="checkbox"/> Full <input type="checkbox"/> Excluding Buccal Cusps |
| <input type="checkbox"/> Lingual Collar _____mm | <input type="checkbox"/> Metal Lingual—Anterior |
| <input type="checkbox"/> Mesial Collar _____mm | <input type="checkbox"/> Full <input type="checkbox"/> 2/3 <input type="checkbox"/> 1/2 |
| <input type="checkbox"/> Distal Collar _____mm | |
| <input type="checkbox"/> 360° Collar _____mm | |

PORCELAIN BUTT MARGIN

- 360° Buccal Only Not Applicable

PONTIC DESIGN

- | | |
|---|--|
| <input type="checkbox"/> Full Ridge | <input type="checkbox"/> Show Metal Strip on Lingual |
| <input type="checkbox"/> Modify Ridge Lap | |
| <input type="checkbox"/> No Contact | <input type="checkbox"/> No Metal Strip on Lingual |
| <input type="checkbox"/> Point Contact | |
| <input type="checkbox"/> Pontic in Socket | |

OCCLUSAL CONTACT

- Full Ridge
 Modify Ridge Lap
 No Contact
 Point Contact

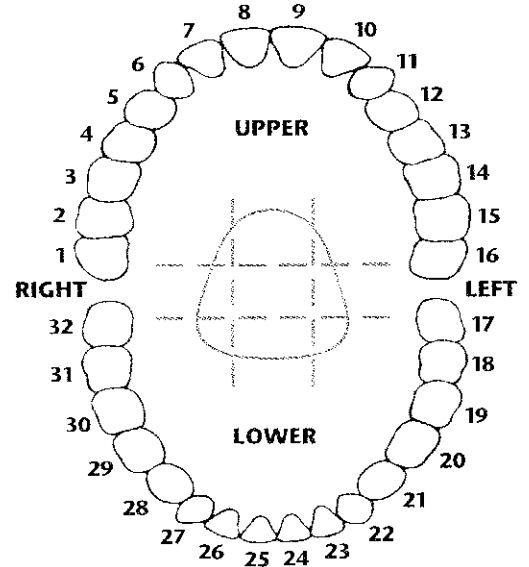
INTERPROXIMAL CONTACT

- Light
 Medium
 Heavy

GINGIVAL EMBRASURE

- Close
 Natural
 Open

TOOTH NUMBER, SHADE & STAINING
(Please circle abutments and cross out pontics)



Tooth Number _____

Shade _____

Occlusal Staining:

- None Light Medium Heavy

Cervical Staining:

- None Light Medium Heavy

IF OCCLUSAL SPACE IS NEEDED

- Adjust Opposing Tooth
 Make Metal Island
 Make Metal Occlusal
 Adjust Prep & Mark Die
 Adjust Prep & Make Reduction Coping
 Contact for Discussion

OTHER SPECIAL INSTRUCTIONS

**Customers standard Protocol is followed unless specified on the case.*