Shaunn's DENTAL LABORATORY

Removable Prosthetics

Case #: _____
Doctor: _____
Patient: _____
Date Requested: _____
Date Shipped: _____

Return For:
❑ Try-In
❑ Completion

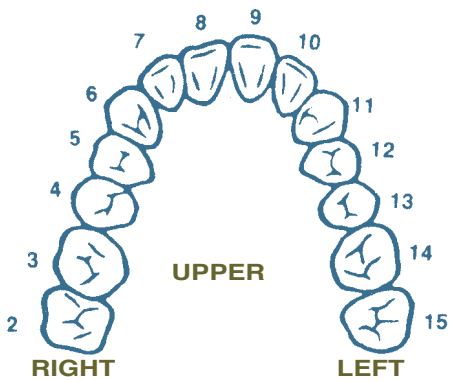
Restoration Type:
❑ Partial Denture
❑ Full Denture

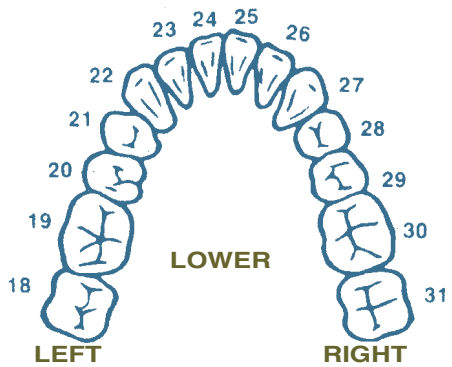
Tooth Mold Selection Anterior _____
Posterior _____

Tooth Shade _____ **Acrylic Shade** _____

Instructions

Cast Partial Design





For Lab Use Only

Signature: _____ License #: _____

CERTIFIED DENTAL LABORATORY

NCDLA NORTH CAROLINA DENTAL LABORATORY ASSOCIATION

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