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 www.roedentallab.com FDA Registration #3004935521

REMOVABLE RESTORATIONS

Please applicable boxes. ROE standards (★) will apply if no selection is made.

- FULL DENTURE** Upper Lower
 ★ESP Bite Rim (Specify Acrylic Shade)
 Economy Bite Rim
 Set-up
 ★Ideal Arrangement
 Staub Cranial
 Match Study Model
 Characterized (See Instructions)
 ★Lingualized Occlusion
 ★Reset for Try-in
 Reset and Finish
 Finish
 Immediate Teeth # _____
 Soft Gasket Teeth # _____

- ESP IVOCAP ACRYLIC SHADE**
 ★Preference (Pink)
 Dark Pigmented

- REPAIRS & RELINES**
 Reline Upper Lower
 Reline w/Soft Liner
 Rebase Denture Upper Lower
 Replace Teeth # _____
 Fracture Repair
 Laser Weld Clasp Retention

- OTHER SERVICES**
 Custom Tray Solid Perf.
 Permanent Soft Liner
 A.E.D. Duplicate Denture
 Bleach Tray Opalescent Foam
 Implant Stent
 Acrylic Guide Rite CT Based

- PARTIAL DENTURE** Upper Lower
 Cast Partial
 Regular Premium Wironium
 Tooth Colored Clasps Teeth # _____
 Laser Weld Clasps Teeth # _____
 Handpacked Pontics Teeth # _____
 Metal Pontics Teeth # _____
 Flipper w/WW Clasps Teeth # _____
 Valplast Partial w/ Cast Framework
 Try-in Casting
 Try-in w/Bite Rim
 Try-in w/Setup

- BITE SPLINT** Upper Lower
 TMJ Design (anterior guidance)
 w/3mm labial coverage
 w/no incisal coverage
 Bruxism Design (flat w/cusp contact)
 w/3mm labial coverage
 w/no incisal coverage
 Neuromuscular Orthotic
 Ortho Acrylic w/Thermaflex
 Ivocap Acrylic w/Thermaflex
 Flexite Plastic w/Thermaflex
 Vac. Form Nightguard Soft Dual
 Elastomer Soft Nightguard

- ORTHODONTICS**
 Fixed Space Maintainer Gelb
 Hawley Tanner Other

- IMPLANT CASE DESIGN**
 Overdenture Hybrid
 CAD Bar Cast Bar Conus Freestanding
 Locator ERA Bredent O-Ring Other

TEETH

- ★Ivoclar
 Economy

SHADE _____

MOULD _____

Doctor Name _____ Date _____

Address _____

Patient Name _____ Age _____ Sex M F

RETURN BY 5:00 P.M. ON _____ Phone _____

Request delivery prior to appointment date, please refer to time requirements.

Send Rx Shipping Labels Boxes Time Requirements

Instructions

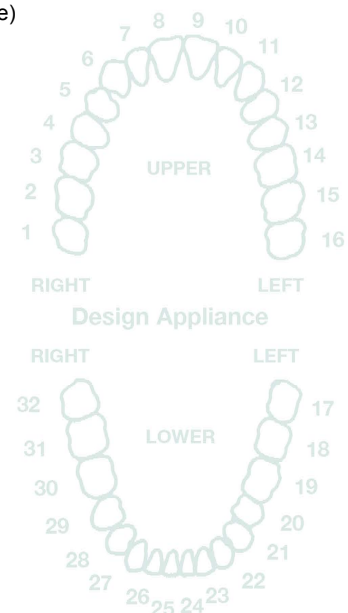
- Snap-on-smile**® (7 units or more)
 Snap-it® (6 units or less)

Patient treatment modality:

- Cosmetic Removable Partial Denture
 Cosmetic Smile Enhancement
 Implant Temporary Restoration
 Raising Vertical Appliance
 Raise posterior _____ mm
 Raise anterior _____ mm

Upper
 Tooth # _____ to Tooth # _____
Lower
 Tooth # _____ to Tooth # _____

Allow 14 laboratory days



Signature _____ **License #** _____

The person signing this work order accepts responsibility for payment and agrees to pay all collection costs including attorney's fees. A 1 1/2% (18%/yr.) finance charge will be added to all balances due over 30 days.

Lab Use Only

Dr. called by _____ Date _____