2868 Westway Dr., Suite G, Brunswick, Oh 44212
330-220-0814 Fax 330-220-0866
info@swandental.net

REMOVABLE RESTORATION

DOCTOR INFORMATION

Name________________________________ Date___________

Address____

Telephone ____

Patient Name:______________________________ Sex F M Age _____

RETURN DATE______________________ TIME__________

○ **CALL BEFORE PROCEEDING WITH CASE**

○ CAST UPPER PARTIAL ○ CAST LOWER PARTIAL ○ DESIGN ONLY

○ UPPER ○ LOWER ○ CUSTOM TRAY ○ BITE BLOCK

○ SETUP ○ IMMEDIATE ○ RESET ○ FINISH

○ DURAFLEX SETUP ○ DURAFLEX FINISH

○ FLIPPER ○ ACRYLIC PARTIAL ○ WROUGHT WIRE

○ TRANSITIONAL PARTIAL ○ TRANSITIONAL DENTURE

○ REPAIR ○ RELINE ○ SOFT LINER ○ REBASE

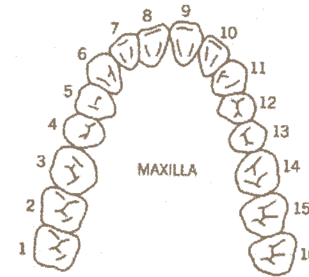
NIGHTGUARD ○ THERMOPLASTIC ○ HARD ○ UPPER ○ LOWER

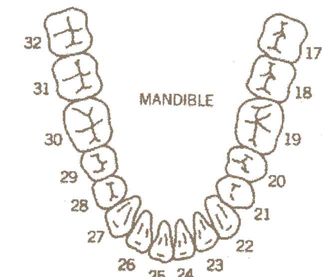
ACRYLIC ○ Fibered Pink ○ Light Reddish Pink ○ Original

○ Coe Mild ○ Coe Moderate

TOOTH SHADE ___________ MOULD ___________

○ **Heraeus Kulzer Mondial** ○ **Ivoclar** ○ **Artic** ○ **Other**





Major Connector ○ Horseshoe ○ Full Palate ○ Palatal Strap ○ A-P Strap

○ Lingual Bar ○ Lingual Plate ○ Embedded Mesh Strength

OK to change clasp type? ○ Yes ○ No

OK to change major connector? ○ Yes ○ No

IF IMMEDIATE CASE, DO WE EXTRACT NOW? ○ Yes ○ No

Failure to mark the above boxes will result in the assumption changes may be made

INSTRUCTIONS

Dr.'s Signature ______________________License #_____________

The person signing this work form accepts responsibility for payments and agrees to pay all collection costs including attorney's fees. (1.5%/18/yr) after 30 days