

PROCAST

DENTIST:

PHONE:

PATIENT:

M AGE

F

DELIVERY DATE:

SPECIAL TRAY BITE BLOCK SET UP TRY IN METAL FRAME TRY IN

FINISH DENTURE IMMEDIATE DENTURE BITE SPLINT MOUTH GUARD

BLEACHING TRAY OTHER _____

F/F F/- -/F P/- -/P PC/- -/PC REPAIR RELINE

SHADE

MOULD

DENTURE TEETH QUALITY RANGE

HIGH MID LOW

