EVO Fusion Milled Denture Rx

DOCTOR INFORMATION

Dr. Name: ______________________
Practice Name: ______________________
Address: ______________________
____
City: __________ State: __________ Zip: __________

Phone: ______________________
Email: ______________________
Fax: ______________________
Doctor's License Number: ______________________

PATIENT INFORMATION

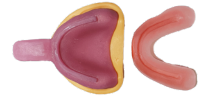
Full Name: ______________________
Age: __________ Gender: __________

Return Date: ______________________
(Please use return date calendar)

1. CUSTOM TRAY *(OPTIONAL)*

Upper ☐ Perforated ☐ Non-Perforated
Lower ☐ Perforated ☐ Non-Perforated

2. BITE REGISTRATION



Upper ☐ Traditional Full Wax ☐ Printed Base + Wax Rim ☐ Duo Bite Block*
Lower ☐ Traditional Full Wax ☐ Printed Base + Wax Rim ☐ Duo Bite Block*

**2-in-1 custom tray and bite block with a wax rim that can be stacked on.*

3. 3D FUNCTIONAL TRY-IN

3D Functional Try-in ☐ Upper ☐ Lower
Tooth Form ☐ Triangular ☐ Oval ☐ Square

Comments: ______________________
____

4. EVO FUSION MILLED DENTURE

EVO Fusion Milled Denture ☐ Upper ☐ Lower
Tooth Form ☐ Triangular ☐ Oval ☐ Square
Tooth Shade: ______________________ *(Vita Classical A1-D4/OM1-OM3)*
Gum Shade ☐ Pink ☐ Brown/Pink
Comments: ______________________
____

5. ORDER A DUPLICATE *(OPTIONAL)*

EVO Fusion Milled Denture
☐ Upper. Qty __________
☐ Lower. Qty __________

Order date of the 1st EVO Fusion Milled Denture: __________

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Doctor's Signature: ______________________ Date: ______________________

DISCLAIMER: If the Technician feels that the bite and/or impressions will lead to an ill-fitting appliance, then they will contact the dental office and ask if they wish to proceed. If the Dentist chooses to proceed, they are liable for the cost of a remake appliance.