

EVO Fusion Printed 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. 1ST 3D PRINTED DENTURE



EVO Fusion Printed Denture Upper Lower
Tooth Form Triangular Oval Square
Tooth Shade A1 A2 A3 B1
 B3 BL C2 D3

Comments: _____

4. ADJUSTMENT – 2ND 3D PRINTED DENTURE (OPTIONAL)

EVO Fusion Printed Denture Upper Lower
Tooth Form Triangular Oval Square
Tooth Shade A1 A2 A3 B1
 B3 BL C2 D3

Comments: _____

5. ORDER A DUPLICATE (OPTIONAL)

EVO Fusion Printed Denture
 Upper. Qty _____
 Lower. Qty _____

Order date of the 1st EVO Fusion Printed Denture: _____

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.