



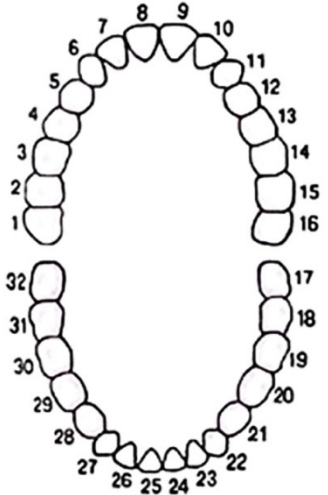
NEW HORIZONS  
DENTAL LABORATORY

7270 W. 188<sup>th</sup> Place, Unit D  
Broomfield, CO 80020  
Phone: 303.469.3362  
Fax: 303.469.0002

### CONVENTIONAL REMOVABLE PRESCRIPTION

Required Information	
Office / Dr. Name:	Patient Name:
Office Phone:	Age: <input type="checkbox"/> M <input type="checkbox"/> F
Email:	P/U Date:
Other:	Due Date:
Preferred Contact: <input type="checkbox"/> Call <input type="checkbox"/> Email	Try In? <input type="checkbox"/> Y <input type="checkbox"/> N

Type and Options	
<b>Full Dentures</b> <input type="checkbox"/> Custom Tray <input type="checkbox"/> Base Plate w/ Bite Rim <input type="checkbox"/> Wax Try-In <input type="checkbox"/> Process/Finish <input type="checkbox"/> Immediate <input type="checkbox"/> Economy	<b>Partial Dentures</b> <input type="checkbox"/> Custom Tray <input type="checkbox"/> Process/Finish <input type="checkbox"/> Frame Try-In w/ Bite Rim <input type="checkbox"/> Esthetic Flexible Cap <input type="checkbox"/> Frame Try-In w/Teeth
<b>Night Guards</b> <input type="checkbox"/> Hard <input type="checkbox"/> Hybrid Hard/Soft	<b>Other Removable Options</b> <input type="checkbox"/> Flipper <input type="checkbox"/> Retainer Clasp: <input type="checkbox"/> Wire <input type="checkbox"/> Ball      Type: <input type="checkbox"/> Essex <input type="checkbox"/> Hawley <input type="checkbox"/> Flexible Partial <input type="checkbox"/> Athletic Guard <input type="checkbox"/> Reline <input type="checkbox"/> Repair

Design Instructions	
<input type="checkbox"/> Call Me Please  <input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular  Shade: _____      Mold: _____  <b>Enclosures:</b> <input type="checkbox"/> Bite Registration <input type="checkbox"/> Model <input type="checkbox"/> Opposing Model <input type="checkbox"/> Upper Impression <input type="checkbox"/> Lower Impression  <b>Additional Instructions:</b>   	

Signature	
Signature: _____	Rx #: _____