FULL DENTURE

Please check the appropriate box

- ☐ Maxillary
- ☐ Mandibular
- ☐ Immediate

- ☐ Reset
- ☐ Baseplate/Bite Rim
- ☐ Set Teeth/Finish
- ☐ Set Teeth/Try-In
- ☐ Finish

Shade: _____

Mold: _____

ACRYLIC

- ☐ Pink
- ☐ Ethnic (choose from below options)
  - ☐ Mild ☐ Moderate ☐ Dark

SPECIAL INSTRUCTIONS

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NDX® Green

FOR LAB USE ONLY:

FROM:

DHS

Medicaid Rx

Due Date: _____

Patient Name: _____

Medicaid ID: _____

P A Number: _____

Birth Date: _____

☐ Female ☐ Male

Provider Number: _____

PARTIAL DENTURE

Please check the appropriate box

- ☐ Maxillary
- ☐ Mandibular
- ☐ Immediate
- ☐ Bent Wire Clasp
- ☐ Cast Clasp

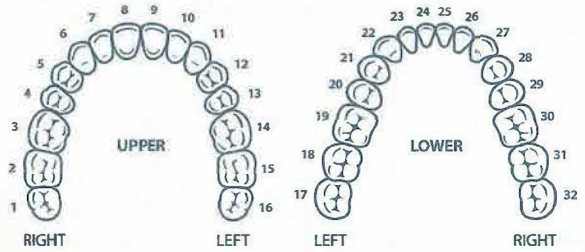
- ☐ Reset
- ☐ Baseplate/Bite Rim
- ☐ Set Teeth/Finish
- ☐ Set Teeth/Try-In
- ☐ Finish

Shade: _____

ACRYLIC

- ☐ Pink
- ☐ Ethnic (choose from below options)
  - ☐ Mild ☐ Moderate ☐ Dark

DESIGN



_____

Dr.'s Signature

_____ _____

License # Date

1099 Wilburn Road | Heber Springs, AR 72543 | P: 800.247.1365 | P: 501.362.3132 | F: 501.362.7934 | NDXGreen.com