

Client Name _____

Address _____

Patient _____ / _____
First Last

Male Female Age _____

Date Required _____

Cast Partial Framework

Major Connector

Maxillary

- Lab Select
- Palatal Strap
- Horseshoe
- Open Palate
- Suad Crossover

Mandibular

- Lab Select
- Lingual Bar
- Lingual Apron
- Kennedy Bar
- Suad Crossover

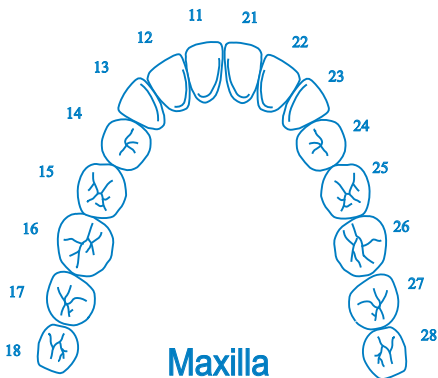
Frame only Frame w/ Thermoflex Clasps

Thermoflex Clasps (only) shade required

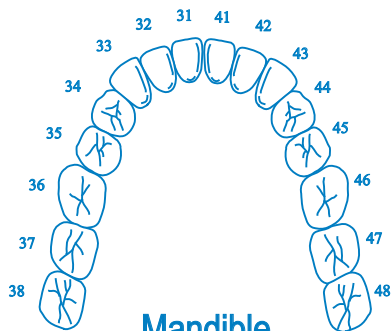
Process & Finish	From Setup	Process only
<input type="radio"/>	Valplast	_____
<input type="radio"/>	Lucitone 199	<input type="radio"/>
_____	Injection Finish	_____
<input type="radio"/>	Ivoclar	<input type="radio"/>
<input type="radio"/>	Success	<input type="radio"/>

Specific Instructions:

Send more Rx-Pads



Maxilla



Mandible

Signature: _____ DD Date ____ / ____ / ____