



REMOVABLE RX

HARRISON DENTAL STUDIO, INC.
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Received _____
Models _____
Tray _____
Bite _____
Partial/Denture _____
Art # _____

CASE NO.

[Empty box for Case No.]

Dr. _____ Date Sent _____
Finish Date _____
Finish Time _____
Patient _____ Shade _____

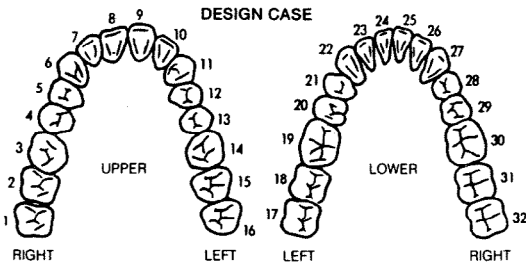
Flipper 1-3 teeth [] Clasps Yes No
Acrylic Partial 4+ teeth []
Full Upper []
Full Lower []
Partial Upper Cast []
Partial Lower Cast []
Flexible Partial []
Clear Clasp []
Invisiguard Splint []
Hard /Soft Splint []
Hard Acrylic Splint []

TEETH
IPN Premium []
Economy Classic []
MOLD Upper
Anterior _____
Posterior _____
Lower
Anterior _____
Posterior _____

E-Mail Photos To:
photos@harrisondentalstudio.com

TRIAL [] FINISH []
SHAPE ETHNIC ACRYLIC
Square []
Tapering []
Ovoid []
SHADES
light medium dark

Special Instructions:



Doctor Sig. _____ Lic. # _____

FM4-RX-003-00 Please send [] RX Forms [] Mailing Boxes [] Shipping Labels