

REMOVABLE PRESCRIPTION



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Baton Rouge, LA 70815

www.bayoustatelab.com

DR. _____ patient _____

DR. phone _____ shade _____

Rx _____ date _____
due date time _____ age _____ sex m f

SELECT TOOTH

- basic premium

ACRYLIC SHADE

- original dark med dark vein

SELECT ARCH

- upper lower

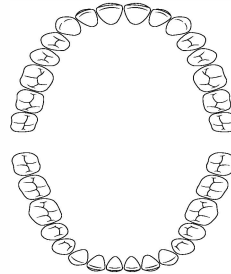
TYPE OF RESTORATION # _____

- CAST PARTIAL FULL DENTURE REPAIR
 ACRYLIC PARTIAL IMM. DENTURE RELINE
 FLEXABLE PARTIAL CUSTOM TRAY NIGHTGUARD
 UNILATERAL PARTIAL BITE RIM TEMP. PARTIAL

ENCLOSED WITH CASE

- opposing bite analog
 # of impressions teeth shade tab
 impression post pics partial
 study model other _____

DESIGN PREFERENCE



- TRY-IN PROCESS



* doctor license _____ doctor signature _____

DAMAS # FM4-4.3-002-00