209 w. central ave.
lompoc, ca 93436
805.735.7888 • 800.585.3111
fax: 805.735.2388
www.robertsondentallab.com

Denture Prescription (Please Print Clearly)

Dr. Name: _____ Date: _____

Patient Name: _____

Try-In Date: _____ Hour: _____

Finish Date: _____ Hour: _____

Instructions: _____

_____

_____

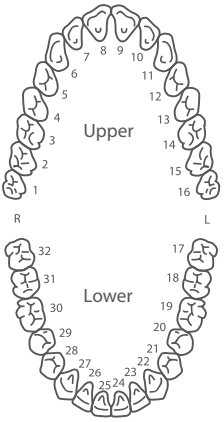
_____

_____

_____

Anteriors

Shade | Mould



Posteriors

Shade | Mould

Facial Characteristics

Check Basic Face Form

☐ Square ☐ Square Tapering

☐ Tapering ☐ Ovoid

☐ Male ☐ Female

☐ Vigorous ☐ Soft

Age _____

License Number: _____ Date: _____

Signature: _____