

# Lucitone Digital Print Denture Rx Order Form

Date: \_\_\_\_\_

## LAB INFORMATION

## OFFICE INFORMATION

Dr.: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

### SHIPPING ADDRESS

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

**BILLING ADDRESS**  Same as above

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

## PATIENT INFORMATION

Name: \_\_\_\_\_

Age: \_\_\_\_\_  Male  Female

Patient number/internal reference: \_\_\_\_\_

## BRIEF TREATMENT DESCRIPTION (Please describe patient's classification)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PRODUCT

	Upper	Lower
Lucitone Digital Try-In	<input type="checkbox"/>	<input type="checkbox"/>
Lucitone Digital Print Denture	<input type="checkbox"/>	<input type="checkbox"/>

Select appropriate patient scenario and follow checklist to ensure laboratory has proper records:

### Existing Denture Patient

- Existing denture with wash impression and bite registration
- Indicate any changes to the existing denture in notes section below
- Patient photos

### New Denture Patient

- Final impressions
- Bite rims with stabilized baseplates
- Mark mid-line, mark distal of cuspids and verify lip support
- Patient photos

## DENTURE SPECIFICATIONS

### Tooth Brand

IPN 3D™   
DS Multilayer PMMA   
Lucitone Digital Value™

### Occlusion

Balanced   
Lingualized

### Tooth Shade

16 A-D, BL1, BL3  
Specify: \_\_\_\_\_

### Base Shade

Original  Original Opaque   
Light  Light Reddish Pink  Dark Reddish Pink

## WIDTH ON CURVE

\_\_\_\_\_mm  
Distal Canine-to-Distal Canine Measurement. (This measurement will be used to select proper mould size, particularly for new denture patients.)

## ADDITIONAL OPTIONS

	Upper	Lower	None
Stippling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rugae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow impression vestibule anatomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name engraving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			

## ORDER INFORMATION

Due Date: \_\_\_\_\_

## CLINICIAN SIGNATURE

\_\_\_\_\_

## NOTES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_