



HELM DENTAL
LABORATORY



DIGITAL ESTHETIC
SOLUTIONS

Digital Dentures RX

www.helmdentallaboratory.com | info@helmdentallaboratory.com

Main Laboratory: 2801 Capital St. Wylie, TX 75098 | 972-442-9772

Date: _____

Doctor Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Email: _____

Phone: _____

Patient Name: _____

Sex: Male Female Age: _____

CASE INFORMATION

TYPE OF DENTURE (select one)

- Immediate
 Replacement

ARCH SELECTION (Please use separate RX for each arch)

- Maxilla
 Mandible

AESTHETIC INFORMATION

TOOTH SET-UP (select one)

- Match existing teeth
 Mould & Shape
 Lab to select teeth (default)

LIP SUPPORT (select one)

- Decrease _____ mm
 Increase _____ mm
 Leave lip support as is (default)

DIGITAL PRINTED DENTURE PACKAGES (per arch)

- Digital printed denture with printed teeth
 Digital printed denture with milled teeth (default)
 Digital printed denture with milled posterior teeth & individual anterior teeth
 Digital printed denture with all individual teeth
 Optional: Duplicate "rescue" denture- digital printed denture with all printed teeth (ordered at time of original denture delivery only)

- Optional:** Duplicate denture, identical to original (ordered anytime with no changes)

Same as original

DIGITAL FP3D FLEX PARTIALS

- 1-3 Teeth
 4-7 Teeth
 8+ Teeth

TYPE OF IMPRESSION

- Scan / Digital

NEXT APPOINTMENT (select one)

- Optional:** Printed try-in, monotone color (no charge but requires an additional appointment)
 Process & finish for final denture

DIGITAL DENTURE PRICING (per arch), includes:

- Digitization of models
- Choice of tooth type (printed, milled, individual, combo as outlines in pricing above)
- Optional printed try-in, monotone color
- Custom designed & printed final denture with patient ID

Please **PRINT** ALL information. Complete all sections that apply to this case & patient's **next** appointment. Keep a copy for your files. We will call you before proceeding if we have any questions.

If no choice is indicated, lab defaults, as indicated will be used.

RECORDS (Please check all that apply & enter info to right)

- Final Shade _____
 Photos (date sent to lab) _____
 Cant corrections _____
 Occlusal plane corrections _____
 Planned changes in VDO _____

ADDITIONAL INSTRUCTIONS: (Please print legibly)



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Doctor's Signature _____

License No. _____

The person signing this authorization and/or the dental practice accepts responsibility for payment of the related charges & agrees to pay all legal & collection costs in the event the account is in collections or litigation, including reasonable fees.