Removable Prosthetic Treatment Record (DENT) _____
Date

Patient Name_____

Prosthetic Type: FUD PUD

FLD PLD

Preliminary Impression:
Maxillary
Mandibular
Alginate
Other:

Final Impression:
Maxillary
Mandibular
Polyvinyl
Border Molding
Other:

Bite Registration:
Wax
Blue Mousse
Facebow
Centric
Excursive

Tooth Selection:
Mold
Shade
Preliminary
Patient Review
Final Approval

Wax Try-in:
Occlusion OK
Speech OK
Stability OK
Esthetic Approval

Delivery:
Disclosure Paste
Instructions
Appointment Tomorrow

Adjustment:
Contour
Occlusal Adjustment
Polyvinyl

Denture Repair:
Reline or Rebase
Replace lost tooth
Repair broken acrylic
Repair to metal framework

Notes:_____

RTO: Procedure(s): _____ ASAP 1 2 3 4 5 6 Days Weeks Months

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **App't on Dentrix List ☐**

Doctor_____ Notation

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