ORTHOSEM
Melton Dental Lab

LABARATORY SHEET

DENTIST:……..

CLINIC:……..

PATIENT DETAILS

FIRST NAME:……..

SURNAME:……..

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RETURN DATE:……

Your case will be returned by close of business on your requested return date.

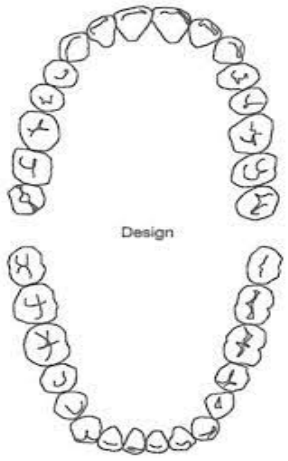
We recommend requesting return at least one day before patient's appointment

DENTURES

FRAMEWORK	PROSTHETICS	REPAIRS & RELINES	MISCELLANEOUS
U L	U L	U L	U L
O O PARTIAL ACRYLIC	O O SPECIAL TRAY	O O BASIC REPAIR	O O BLEACHING TRAY
O O FULL ACRYLIC	O O REGISTRATION RIMS	O O REPAIR ADDITION	O O CLEAR STENT
O O VERSACRYL	O O TRY IN FRAMEWORK	O O LASER WELD	O O MOUTHGUARD
O O VALPLAST	O O TRY IN TEETH	O O PARTIAL RELINE	O O CLEAR SUCKDOWN STENT
	O O RETRY TEETH	O O FULL RELINE	O O OTHER
	O O FINISH DENTURE	O O REBASE	

ORTHODONTICS

OCCLUSAL SPLINTS	REMOVABLE	RETAINER
U L	U L	U L
O O HARD	O O SCHWARTZ	O O HAWLEY
O O SOFT	O O SCHWARTZ	O O BEGG
O O HARD/SOFT	O O TWIN BLOCK	O O SPRING HAWLEY
O O MISHINGEN	O O BIONATOR	O O SPRING ALIGNER
	O O OTHER	O O LINGUAL ARCH (3-3)
		O O OTHER



INSTRUCTIONS

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SHADE:……..

34/62 Andrew St,

Melton South 3338 VIC 0426 903 772 Orthosem@meltondentallab.com.au