

PROSTHETICS



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ALTERATION AUTHORISED BY:

SIGNED: DATE:

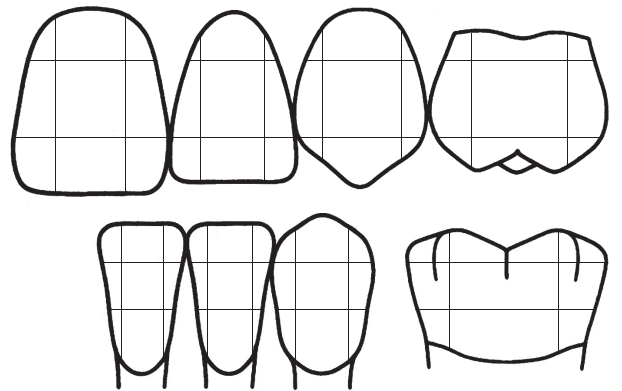
DENTIST		DATE
PRACTICE		
JOB No		DELIVERY DATE
PATIENT NAME		
PATIENT AGE		
DATES		CHECKED
BITE		
TRY		
RETRY		
FINISH		

SPECIAL TRAY	UPPER <input type="checkbox"/>	LOWER <input type="checkbox"/>
BITE BLOCK	UPPER <input type="checkbox"/>	LOWER <input type="checkbox"/>
CHROME	UPPER <input type="checkbox"/>	LOWER <input type="checkbox"/>
FLEXIBLE DENTURE	UPPER <input type="checkbox"/>	LOWER <input type="checkbox"/>

NOTES:

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8



SHADE MOULD