HICKS
DENTAL
LABORATORY
Fax 810-984-0078
Or Call 810-984-4070

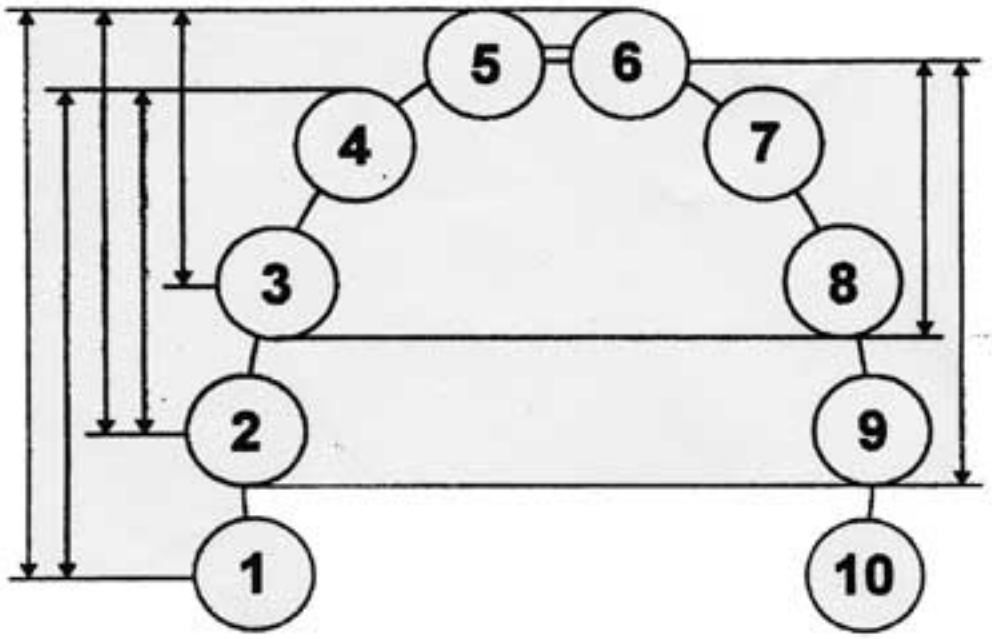
IMPLANT OVERDENTURE LAB SHEET

DOCTOR: _____

CASE No.: _____

PATIENT NAME: _____

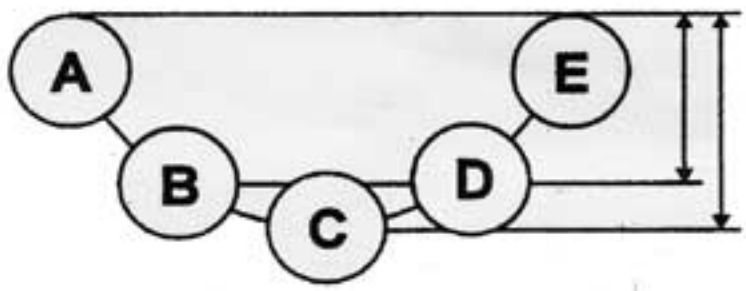
MAXILLA



ANTERIOR - POSTERIOR DISTANCE

_____mm

MANDIBLE



ANTERIOR - POSTERIOR DISTANCE

_____mm

PROSTHESIS MOVEMENT 1 2 3 4 5 6

PROSTHESIS TYPE RP-4 RP-5

ATTACHMENT TYPE & NUMBER ___O-RING___HADER ___DOLDEF R

LOCATION: _____

CROWN-IMPLANT RATIO ☐<1 ☐1/1 TO 2/1 ☐>2/1

ANTERIOR - POSTERIOR DISTANCE (X) _____mm

CANTILEVER OF BAR ☐0 ☐½X ☐1X ☐1½X ☐2X ☐2½X

DENTURE TOOTH _____

LAST TOOTH IN ARCH _____

ANTERIOR _____

POSTERIOR _____

TOOTH SHADE _____

GINGIVAL SHADE _____

☐ DIAGNOSTIC WAX-UP

☐ SURGICAL/PROSTHETIC TEMPLATE

☐ MODIFIED CUSTOM TRAY

☐ DELIVERY DATE:

SPECIAL INSTRUCTIONS