UNICE
Dental Art Ltd.

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Toll Free) 1-866-939-2515
Send photo by email to info@unicedental.com

Doctor: _____ Date: _____

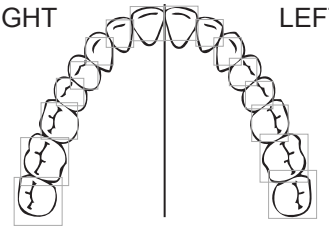
Patient: _____ Sex: _____ Age: _____

Time Wanted: _____

❑ Complete Denture	❑ Cast Partial	❑ Acrylic Partial
❑ Finish	❑ Wax Try-In	❑ Bite Block
❑ Reline	❑ Repair	❑ Custom Tray

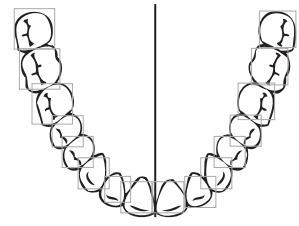
UPPER

RIGHT LEFT



LOWER

RIGHT LEFT



PARTIAL DENTURE DESIGN

Rx_

SHADE _____ MOLD _____

❑ Patient will come for custom shade

❑ Teeth to be extracted: # _____

Doctor's Signature _____