



710 Grand Avenue
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PARTIAL DESIGN

DOCTOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_) _____ Email _____

PATIENT INFORMATION

PATIENTS NAME: _____

AGE: _____ MALE FEMALE

DATE STARTED: _____ / _____ / _____

RETURN DATE: _____ / _____ / _____

DESIGN

MAXILLARY

MANDIBULAR



Horseshoe



Anterior Posterior Bar



Full Metal Palate



Palatal Strap



Posterior Palatal Strap



Cast Base Metal Post Dam



Full Palate Mesh Cast Base



Lingual Bar



Lingual Plate



Kennedy Bar



Cingulum Bar



Mesh Strengtheners



Bar Strengtheners



Latch Lock

CLASPS

- Akers..... _____
- DBL Akers..... _____
- Ring _____
- Equipose..... _____
- Fish Hook _____
- Snubber..... _____
- Roach or T-bar..... _____
- 1/2 Roach _____
- I Bar _____
- Flag..... _____
- Umbrella _____
- DBL I..... _____
- DBL T..... _____

TOOTH

PROCESSED TEETH

- Boxing Only
 - Steeles Facings
 - Processed Facings
 - Tube Teeth
 - Backings Only
 - Onlays - Acrylic
 - Onlays - Metal
 - Metal Dummy
 - Metal Bite Pad
- DESIGN RESTS TOOTH#**
- Mesial Rests..... _____
 - Distal Rests..... _____
 - Cingulum Rests..... _____
 - Incisal Rests..... _____

DESIGN CHANGE

- OK to change design
- OK to relieve opposing
- Doctor will relieve opposing

INSTRUCTIONS

UPPER

LOWER

Authorized Signature: _____