GOLD COAST DENTURES BY Design

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Dentist Stamp

Date: ..... Phone: .....

Patient: ..... Appliance: .....

Areas of Concern

UPPER RIGHT								UPPER LEFT							
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
LOWER RIGHT								LOWER LEFT							

SHADE

APPT. TIMES
Trays
Bites
Try In
Retry
Finish

Instructions: .....