DENTAL PRESCRIPTION FORM

DREAM Dental Lab,
Unit 1, Kingseat Business Park, Kingseat Avenue,
Newmachar AB21 0AZ
T: 01651 567558 WhatsApp: 07553 336675
E: info@dream.scot

Case/Lab Number

Patient Name: _____ Dentist: _____

DOB: _____ Clinic: _____

Gender: _____ Address: _____

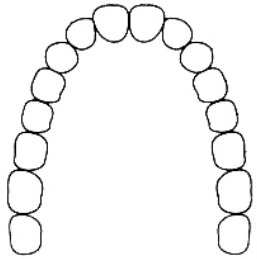
NHS ☐

PRIVATE ☐

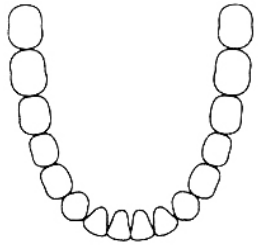
DREAM ☐

Today's Date: _____ Date Required: _____ Disinfected? Yes ☐	Instructions:	Signatures: Clinician: _____ Stage Technician: _____
Today's Date: _____ Date Required: _____ Disinfected? Yes ☐	Instructions:	Signatures: Clinician: _____ Stage Technician: _____
Today's Date: _____ Date Required: _____ Disinfected? Yes ☐	Instructions:	Signatures: Clinician: _____ Stage Technician: _____
Today's Date: _____ Date Required: _____ Disinfected? Yes ☐	Instructions:	Signatures: Clinician: _____ Stage Technician: _____

☐ Acrylic ☐ Co Cr



☐ Acrylic ☐ Co Cr



Shade

Additional Details:

Teeth to be replaced

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

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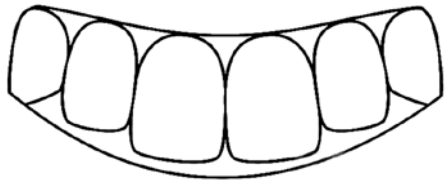
Additional Information:



Clinical Photos Taken ☐

DISCLAIMER: This is a custom made device that has been manufactured to satisfy the design characteristic and properties specified by the prescriber for the above named patient. This medical device is intended for exclusive use by this patient and conforms to the relevant essential requirements specified in Annex 1 of the Medical Devices Directive and the UK Medical Devices Regulations.

Signature: _____