



E Tech Dental
laboratory

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Denture Prescription

Dr. Name: _____ Date: _____

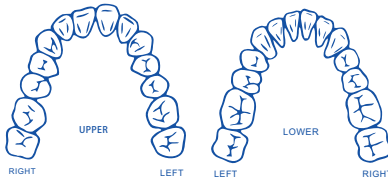
Patient Name: _____

Try-In Date: _____ Hour: _____

Finish Date: _____ Hour: _____

Instructions: _____

DESIGN CASE HERE



Facial Characteristics

Check Basic Face Form

- Square
- Square Tapering
- Tapering
- Ovoid

Male Female

Vigorous Soft

Age: _____

License Number: _____ Date: _____

Signature: _____