KINGDOM
DENTURE CLINIC

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3/3 Ted Ovens Drive, Coffs Harbour

DATE: / /

PATIENT NAME: _____

REFERRED BY: _____

FULL DENTURE: ☐F/F ☐F/- ☐-/F

PARTIAL ACRYLIC: ☐UPPER ☐LOWER

PARTIAL CHROME: ☐UPPER ☐LOWER

IMMEDIATE: CLEARANCE ☐F/F ☐F/- ☐-/F
☐UPPER ☐LOWER
PARTIAL
EXTRACTION _____

IMMEDIATE ADDITION: ☐PARTIAL ACRYLIC ☐PARTIAL CHROME
☐EXTRACTION

IMPLANT OVERDENTURE: ☐UPPER ☐LOWER

RELINE: ☐FULL ☐PARTIAL

MOUTHGUARD:

REPAIR:

ADDITIONAL NOTES: