Mabel DENTAL LAB

CASE EVALUATION FORM – REMOVABLE RESTORATIONS

Doctor: _____ Patient: _____ Date: _____

YOUR OPINION MATTERS

Tell us how we're doing. Please provide us with your case feedback.

Please rate from 1 to 5 (5 being excellent and 1 being unacceptable)

Rx – design / preferences followed	1	2	3	4	5	n/a
Borders + Flanges: Thickness / Uniform	1	2	3	4	5	n/a
Frenum / Tori Clearance / Postdam Placement	1	2	3	4	5	n/a
Underside: Defect-free / Clean	1	2	3	4	5	n/a
Tooth Selection: Shade / Shape / Size	1	2	3	4	5	n/a
Anterior / Posterior Set-up	1	2	3	4	5	n/a
Finish / Polish	1	2	3	4	5	n/a
Framework: Fit / Passive	1	2	3	4	5	n/a
Clasp: Contour / Fit	1	2	3	4	5	n/a
Turnaround Time	1	2	3	4	5	n/a
Communication – notified case received/completed	1	2	3	4	5	n/a
Other Remarks (continue on back if needed):						

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