

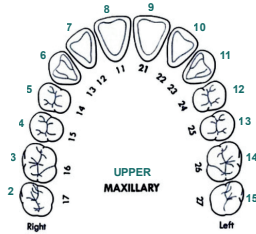
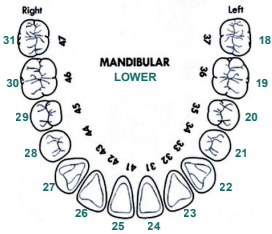
Dentist: _____ Phone Number: _____

Clinic: _____

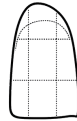
Address: _____

Patient: _____ Gender: Female / Male

Due Date: _____



SHADE NOTES:



CASE DESCRIPTION

Restoration / Appliance Type: _____

Material: _____

Pontic Design: _____

Further Instructions:

Signature: _____

Rx Date: _____