

Dentist: _____

Address: _____

Date Sent: _____ Date Due: _____

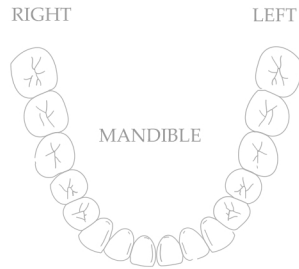
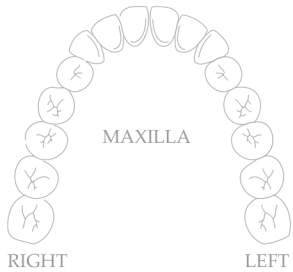
R Patient: _____ M F Age _____

Restoration
Type: _____



Shade: _____

Teeth #: _____



License #: _____ Signature: _____

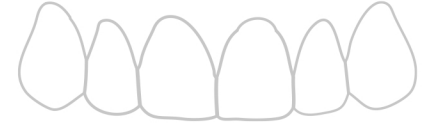
Dentist: _____

Address: _____

Date Sent: _____ Date Due: _____

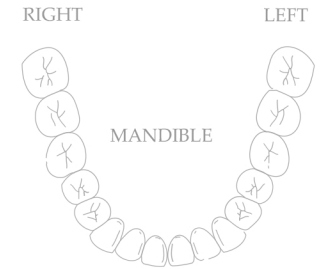
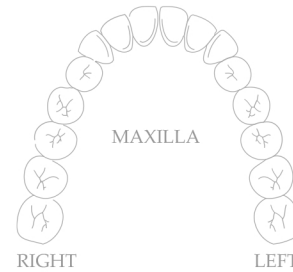
R Patient: _____ M F Age _____

Restoration
Type: _____



Shade: _____

Teeth #: _____



License #: _____ Signature: _____