

From Dr: _____

Address: _____

Patient's Name:_____ Sex:_____ Age:_____

RETURN DATE

◀

IMPORTANT

▶

SHADE

MOLD

☐ Try In
☐ Finish

☐ CERAMIC

☐ CROWN & BRIDGE

☐ PARTIAL

☐ DENTURE

PROSTHETIC IDENTIFICATION

[illegible]

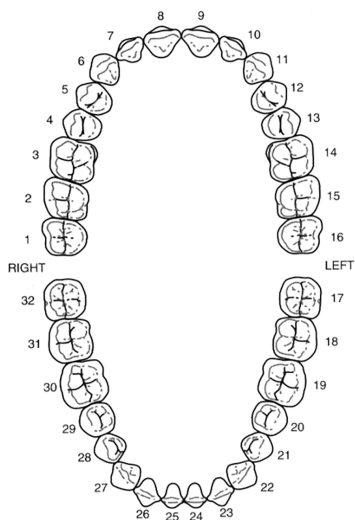
PLEASE PRINT: FIRST INITIAL; SPACE; LAST NAME

DESIGN CASE HERE

INSTRUCTIONS:

ACRYLIC SHADE

☐ 199 LT REDDISH ☐ ETHNIC ☐ ETHNIC
 ORIG PINK LT DK



CASE HAS BEEN DISINFECTED? ☐ YES ☐ NO

PERSONAL SIGNATURE OF DENTIST

LICENSE NUMBER

DATE _____

☐ MAILING LABELS ☐ MAILING BOXES ☐ RX PADS