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DATE _____

DOCTOR _____

ADDRESS _____

TELEPHONE ( ) _____

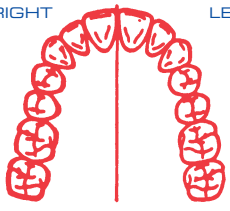
_____

PATIENT'S FULL NAME (Important - Please Print)

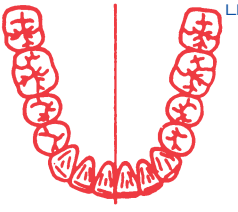
_____

UPPER LOWER

RIGHT LEFT RIGHT LEFT



SHADE:



AGE _____ PARTIAL DENTURE DESIGN SEX _____

DATE REQUIRED

DEPT. OF PUBLIC HEALTH ☐

DUE _____ TIME _____

PLEASE CHECK APPROPRIATE BOX

BITE ☐ TRY IN ☐ FINISH ☐

℞ _____