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Date _____

Doctor _____

Address _____

Telephone ( ) _____

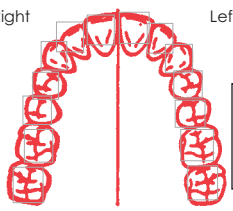
_____

Patient's Full Name (Important - Please Print)

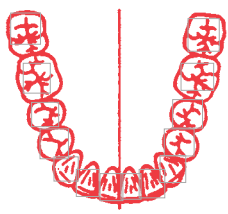
_____

Upper Lower

Right Left Right Left



Shade:



Age _____ Partial Denture Design Sex _____

Date Required

Due _____ Time _____

Please Check Appropriate Box

Bite ☐ Try In ☐ Finish ☐

℞ _____