



**THE AURUM GROUP®**

HUB DENTAL LABORATORY  
 (A member of the Aurum Group of Companies)  
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 Moncton, NB E1C 1X2

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 Email hubdental@aurumgroup.com

Date \_\_\_\_\_

Doctor \_\_\_\_\_

Address \_\_\_\_\_

Telephone ( ) \_\_\_\_\_

Patient's Full Name (Important - Please Print) \_\_\_\_\_

	Upper		Lower
Right			Left
Left	<div style="border: 1px solid black; width: 100px; height: 50px; display: flex; align-items: center; justify-content: center;">                 Shade:             </div>	Right	
	Partial Denture Design		Left
Age _____			Sex _____

**Date Required**

Due _____	Time _____
<small>Please Check Appropriate Box</small>	
Bite <input type="checkbox"/>	Try In <input type="checkbox"/>
	Finish <input type="checkbox"/>

**Rx** \_\_\_\_\_

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