

DOCTOR: _____ PATIENT: _____
PLEASE PRINT PLEASE PRINT

MAILING ADDRESS: _____

CITY: _____ STATE, ZIP: _____

PHONE: _____ EMAIL: _____

M F AGE: _____ DATE PREPARED: _____

DATE DUE ON (BY 5:00 P.M.): _____ DATE RECEIVED @ LAB: _____

CONTACT

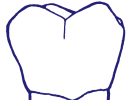
- LIGHT
- MEDIUM (Default)
- HEAVY-SCRAPE CAST

OCCLUSION

- OUT OF OCCLUSAL
- SLIGHTLY OUT (Default)
- HEAVY-TOUCHING OPPOSING



SHADE _____



I N S T R U C T I O N S

Signature _____

License No. _____