



#2 West Drive | Suite 130 | Chesterfield, Missouri 63017 | Tel 636.519.0200

DR. \_\_\_\_\_

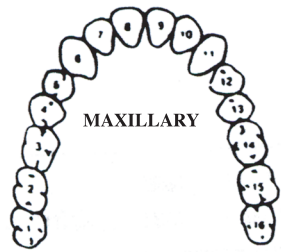
ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_

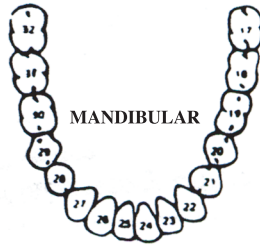
PATIENT NAME \_\_\_\_\_

RETURN DATE \_\_\_\_\_ TRY IN \_\_\_\_\_ FINISH \_\_\_\_\_

SHADE \_\_\_\_\_ TYPE OF METAL \_\_\_\_\_ TOOTH TYPE \_\_\_\_\_



INDICATE CHARACTERIZATIONS  
PONTIC DESIGN (CIRCLE)



INSTRUCTIONS:

OVER

Dentist's Signature \_\_\_\_\_

Dentist's License Number \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_



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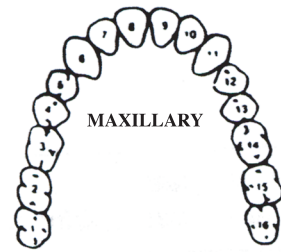
ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_

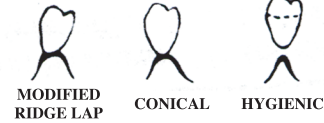
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INDICATE CHARACTERIZATIONS  
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INSTRUCTIONS:

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