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Dr. Name _____ Phone # _____

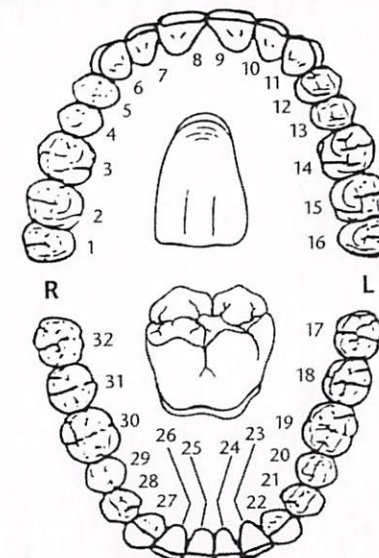
Patient Name _____

Today's Date _____ Deliver by 5 p.m. on _____

Enclosed with case: ☐ Impressions ☐ Implant Parts ☐ Models ☐ Bite ☐ Photos ☐ Other: _____

DESCRIPTION OF WORK:

SHADE



IF NO OCCLUSIONAL CLEARANCE

- ☐ Call Doctor
☐ Adjust Opposing
☐ Metal occlusion

OCCLUSAL STAINING

- ☐ None ☐ Light* ☐ Medium ☐ Dark

PONTIC DESIGN



Signature _____ License # _____