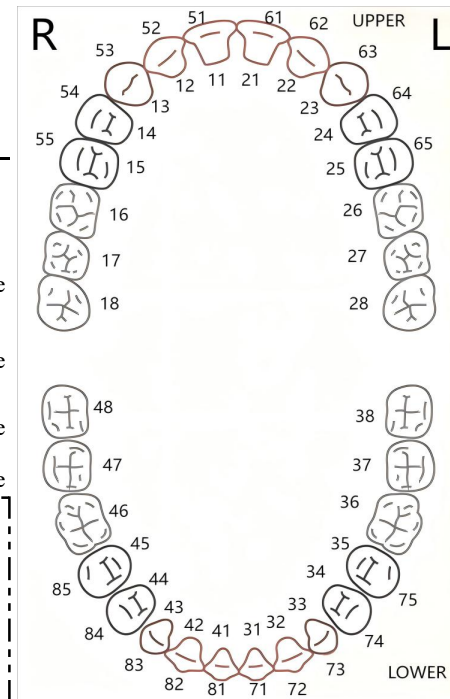


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| DR.                                         |  | <b>Full Metal</b><br><input type="checkbox"/> Crown<br><input type="checkbox"/> Inlay/Onlay<br><input type="checkbox"/> Post                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | <b>Composite</b><br><input type="checkbox"/> Crown<br><input type="checkbox"/> Inlay/Onlay<br><input type="checkbox"/> Veneer         |                      | <b>E-max</b><br><input type="checkbox"/> Crown<br><input type="checkbox"/> Inlay/Onlay<br><input type="checkbox"/> Veneer                                                             |  | <b>CAD/CAM</b><br><input type="checkbox"/> Por.Zir.<br><input type="checkbox"/> Full Zir<br><input type="checkbox"/> Scan only<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | <b>Implant</b><br><input type="checkbox"/> Cement-Retained<br><input type="checkbox"/> Screw-Retained<br><input type="checkbox"/> Screw + Cement Combined<br><input type="checkbox"/> Custom made abutment |                                                                                                                                                            | <b>P F M</b><br><input type="checkbox"/> Crown<br><input type="checkbox"/> Bridge<br><input type="checkbox"/> Onlay |  | Case No.:                                                                                                                          |  |                                                                                                                                 |  |
| Dr code                                     |  | <b>Alloy</b><br><input type="checkbox"/> N.P (Ni.Free)/N.P <input type="checkbox"/> 0% - 2% Precious <input type="checkbox"/> 50% - 80% Precious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| PATIENT :                                   |  | <b>Particular Design</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| AGE:                                        |  | <b>Margin</b><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       | <b>Occlusion</b><br> |                                                                                                                                                                                       |  | <b>Pontic Design</b><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                            | <b>Occlusal Contact</b><br><input type="checkbox"/> Light Contact*<br><input type="checkbox"/> Tight Contact<br><input type="checkbox"/> _____mm Clearance |                                                                                                                     |  | <b>Intorproximal</b><br><input type="checkbox"/> Natural*<br><input type="checkbox"/> Close<br><input type="checkbox"/> Somi Close |  | <b>Proximal Contact</b><br><input type="checkbox"/> Broad<br><input type="checkbox"/> Normal*<br><input type="checkbox"/> Tight |  |
| Date Send                                   |  | <b>PARTIALS &amp; DENTURES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Date IN                                     |  | <input type="checkbox"/> Cast partial wax setup w/teeth <input type="checkbox"/> Cast partial Denture setup & Finished w/teeth<br><input type="checkbox"/> Full Denture Setup/ Wax Only w/teeth <input type="checkbox"/> Full Denture setup & Finished w/teeth<br><input type="checkbox"/> Partial Wax Try -In <input type="checkbox"/> Framework only<br><input type="checkbox"/> Valplast setup only <input type="checkbox"/> Valplast Partial Setup & Finished w/teeth<br><input type="checkbox"/> Flipper Valplast- up to 3 teeth <input type="checkbox"/> Valplast partial Framework Finished w/teeth<br><input type="checkbox"/> Nightguard Soft <input type="checkbox"/> Nightguard Hard <input type="checkbox"/> Nightguard Hard / Soft <input type="checkbox"/> Nightguard w / Table NIT<br><input type="checkbox"/> Custom Tray <input type="checkbox"/> Ortho Clear Tray <input type="checkbox"/> Hawley Retainer <input type="checkbox"/> Bite Block / Wax Rim<br><input type="checkbox"/> Reline <input type="checkbox"/> Nesbit <input type="checkbox"/> Acrylic <input type="checkbox"/> Valplast <input type="checkbox"/> Retainer |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Bite block                                  |  | <input type="checkbox"/> partial Denture Finish only<br><input type="checkbox"/> Full Denture Finish Only<br><input type="checkbox"/> Acylic Partial Denture<br><input type="checkbox"/> Valplast Finish only<br><input type="checkbox"/> Flipper Acrylic-up to 3 teeth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Try In                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Retry in                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Finish                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| PROVIDED INFORMATION                        |  | <b>IMMEDIATE :Tooth Number(s) to be removed</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Working study/<br>model Bite<br>model Model |  | <b>Make Clasps Only</b><br><input type="checkbox"/> Valplast<br><input type="checkbox"/> Wrought Wire<br><input type="checkbox"/> Metal<br><input type="checkbox"/> Clear                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>TISSUE/GUM color</b><br><input type="checkbox"/> Meharry<br><input type="checkbox"/> Normal Pink<br><input type="checkbox"/> Clear |                      | <b>ENCLOSED WITH CASE</b><br><input type="checkbox"/> photos<br><input type="checkbox"/> Impressions<br><input type="checkbox"/> Models<br><input type="checkbox"/> Bite Registration |  | <b>Occlusal stain</b> <input type="checkbox"/> light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> None<br><b>Cervical Stain</b> <input type="checkbox"/> light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> None<br><b>Fluorosis/Calcify</b> <input type="checkbox"/> light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> None<br><b>Glaze Texture</b> <input type="checkbox"/> light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> None |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Impression tray                             |  | <b>Special instructions:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Articulator                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Others                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
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| order processing center                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| Enid Wray                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| enidwray_manufacturer@outlook.com           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |
| call / whatsapp (+86)13603066591            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                      |                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                            |                                                                                                                                                            |                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                 |  |



SHADE: