PATIENT

Name_____

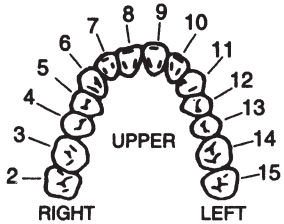
Address _____

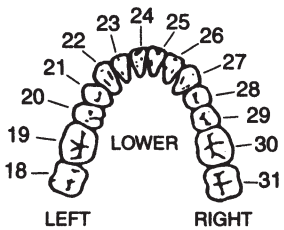
City _____

Male ❒ Female ❒ Shade _____ Enclosed ❒

Date wanted_____ Hour_____ A.M.
(Figure using FULL working days at the lab.) P.M.

SEND TOP 2 COPIES TO LAB





DR._____

Account Name_____

Phone_____ License _____ Date _____

Signature _____

DENTURE DEPOT INC.

717 Lingco St., Suite 201 • Richardson, Texas 75081

972-235-8600

Michael James McSpadden, C.D.T.

REGISTRATION #03031