

PMYKTEK dental lab, Inc.

440-843-9575

Dr. _____
 Address _____
 Phone _____
 Patient _____

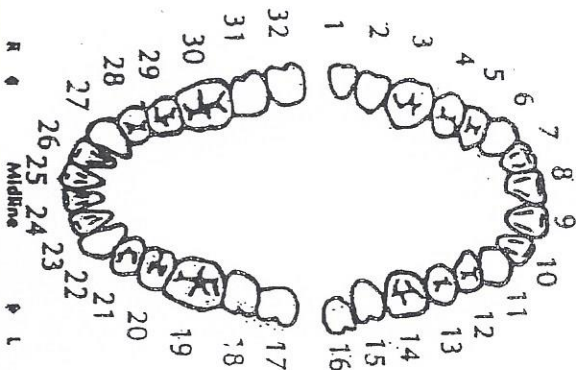
DENTURES

PLEASE SELECT ONE

- ECONOMY
 - STANDARD
 - PREMIUM
- Shade _____ Mould _____
 Age _____ M _____ F _____

- | | | | |
|------------------------------------|-------------------------------------|---|---------------------------------------|
| TEETH | SET-UP | FINISH | MISC. |
| <input type="checkbox"/> Porcelain | <input type="checkbox"/> Try-In | <input type="checkbox"/> Coe-Lor | <input type="checkbox"/> Custom Tray |
| <input type="checkbox"/> Plastic | <input type="checkbox"/> Re-Set | <input type="checkbox"/> Char. Lucitone | <input type="checkbox"/> Occlusal Rim |
| <input type="checkbox"/> IPN | <input type="checkbox"/> Inmed. | <input type="checkbox"/> Hydrocryl | <input type="checkbox"/> Flipper |
| | <input type="checkbox"/> Frame Work | <input type="checkbox"/> Standard | <input type="checkbox"/> Reline |
| | | | <input type="checkbox"/> Repair |

PLEASE DISINFECT ALL IMPRESSIONS
 CASE DISINFECTED YES NO



Doctor's Signature _____ License No. _____

Date _____ Return Date _____

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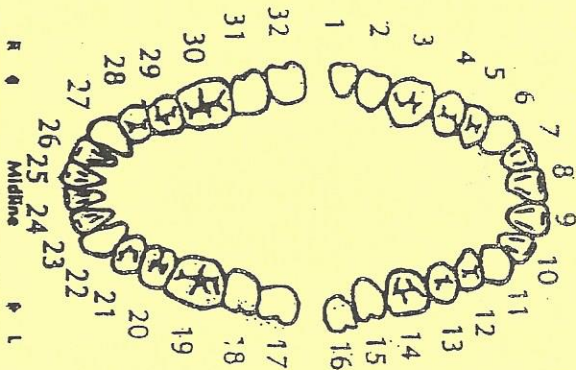
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