

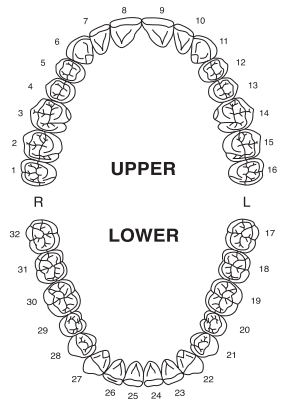
Doctor's name _____ Delivery by 5 PM on _____

Patient's name _____ Sex: M F

Shade _____ Wax Try-in

Appt. date _____ Time _____

Rx



Dentist Signature _____

License # _____ Date _____