J&F Dental Labs

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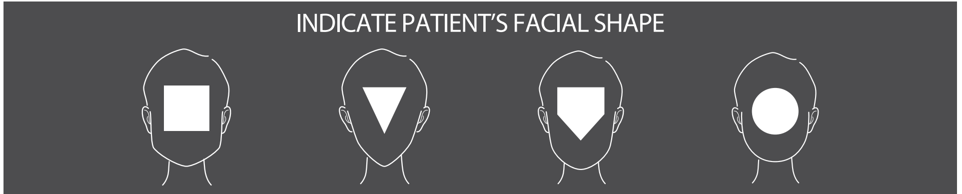
Doctor's name ______________________________ Delivery by 5 PM on __________

Patient's name ____ Sex: ☐ M ☐ F

Shade ________________ Wax Try-in ☐

Appt. date _____________ Time ____________



☐ Square ☐ Tapering ☐ Square Taper ☐ Ovoid

Indicate Anterior Arrangement #1 - 24 ____________________

℞

UPPER

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

R L

LOWER

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Dentist Signature ____

License # _____________________________________ Date _____________________