

DENTIST _____

PATIENT _____

DATE _____ SEX _____ AGE _____

SHADE _____ DATE REQ _____ TIME _____

SPECIAL TRAY _____

BITE REGISTRATION _____

TRY IN _____

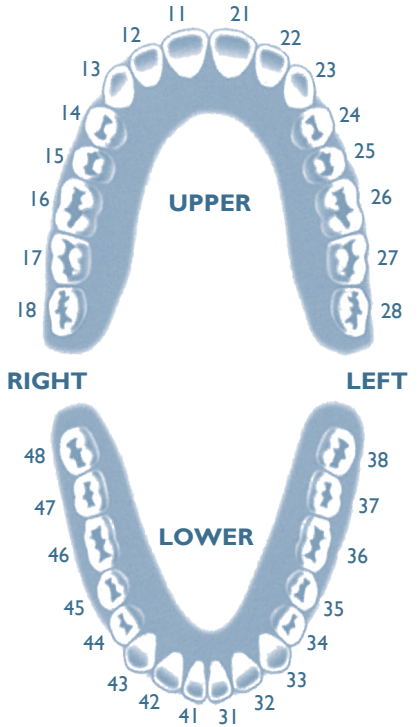
FINISH _____

- | | |
|--|--|
| <input type="checkbox"/> OCCLUSAL SPLINT | <input type="checkbox"/> RELINE |
| <input type="checkbox"/> REPAIR / ADDITION | <input type="checkbox"/> MOUTHGUARD |
| <input type="checkbox"/> BLEACHING TRAYS | <input type="checkbox"/> IMPLANT STENT |

INSTRUCTIONS



PARAGON DENTAL



OFFICE USE ONLY