

LAB USE ONLY

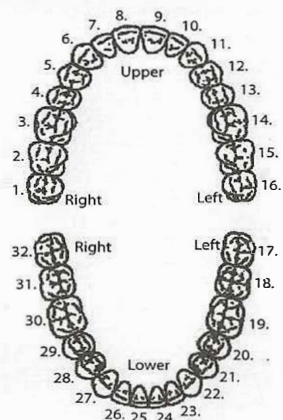
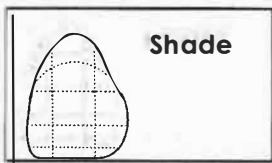
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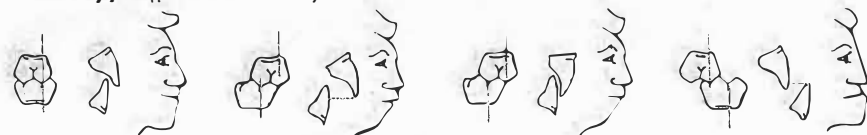
DOCTOR	PATIENT <input type="checkbox"/> Male <input type="checkbox"/> Female	
ADDRESS / PHONE	Rx Date	DUE DATE

** Please send pictures to Photos@ODSinc.com*

- Immediate Denture
- Occlusal Rim or Custom Tray
- Jig & Custom Tray
- Set-up for Wax Try-in
- Titanium Bar
- Cast Partial or Cast Mesh Work
- Valplast Partial
- Reset
- Process & Finish
- Occlusal Guard
- Repair / Reline



Bite Type (please circle)



INSTRUCTIONS

DOCTOR'S SIGNATURE _____ LICENSE # _____

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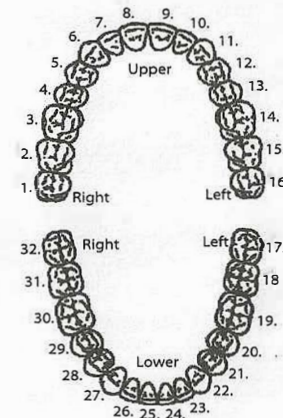
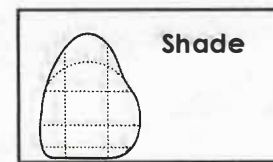
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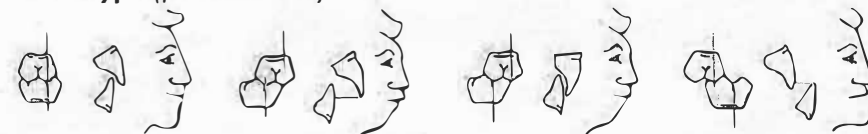
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