GDL

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LAB USE ONLY

REC'D _____

OUT _____

RETURN _____

FROM: **DATE:**

DR. _____

OFFICE ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT'S NAME _____

TYPE OF RESTORATION _____

APPOINTMENT DATE ___/___/___ **TIME** ___:___ AM PM ☐ TRYIN OR ☐ FINISH

* MUST SPECIFY DENTURE TYPE: ☐ ECONOMY ☐ REGULAR ☐ PREMIUM ☐ OTHER _____

INSTRUCTIONS*

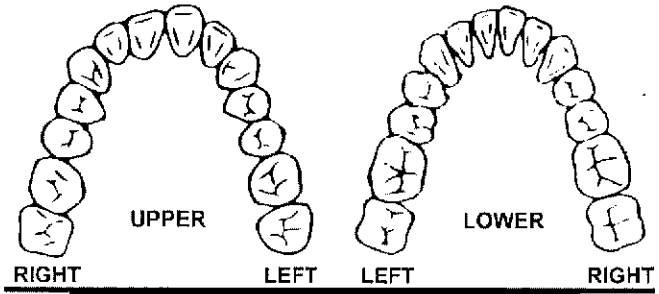
	Anterior		Posterior	
Upper	shade	mould	shade	mould
Lower	shade	mould	shade	mould

DENTIST LICENSE NUMBER _____ DATE ___/___/___

_____

PERSONAL SIGNATURE OF DENTIST

DESIGN CASE HERE



INSTRUCTIONS *(Continued)*