



10565 N. 114th ST., #111
SCOTTSDALE, AZ 85259
(480) 661-6489

FROM: _____ ORDER NUMBER _____

DR _____

Address _____

City _____ State _____ Zip _____

Patient's Name or ID _____

(Construct and deliver to undersigned only, the herein described dental restoration)

INSTRUCTIONS:

SHADE _____ MALE FEMALE TRY
IN _____

DENTIST'S LICENSE NUMBER: _____ Date
Wanted _____

Dated: The _____ day of _____