

**DATE REQUESTED**

Date \_\_\_\_\_  
Day / Month / Year

\_\_\_\_\_  
Day / Month / Year

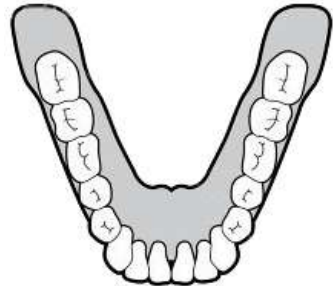
Office \_\_\_\_\_

Dentist \_\_\_\_\_

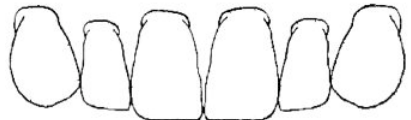
Patient \_\_\_\_\_

Sex: M  F  Age \_\_\_\_\_

Detailed instruction



Shade Details



**Return to me as a:**

- wax up
- diagnostic
- try in
- bisque bake
- finish

DENTIST'S SIGNATURE \_\_\_\_\_