To: GREENFIELD DENTAL ARTS

207 Silver Street
Greenfield, MA 01301
(413) 774-7906

Dr. ______________________ Date ______________________

Street ______________________

City ______________________ State ____________ Zip ____________

Patient ______________________ Time Wanted Try-In ____________

Case ______________________ Finished ____________

TEETH TO BE USED

Brand ______________________ Shade ____________ Mould ____________

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Type of Restoration ______________________

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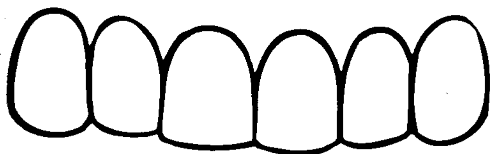

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Instructions: ______________________

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Dentist's Signature

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License No.

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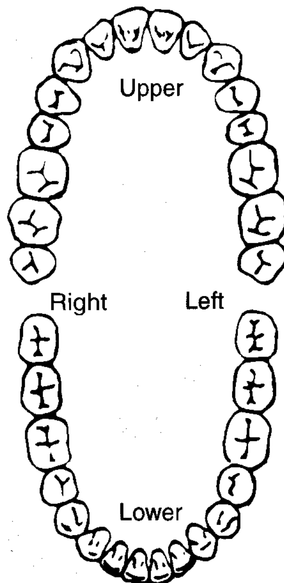
Tel. No.

Design Case



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