

DR. \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

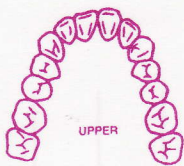
PATIENT \_\_\_\_\_ TRY-IN

DATE REQUIRED \_\_\_\_\_ (X) A.M.  P.M.

SIGNATURE \_\_\_\_\_ DDS. SHADE \_\_\_\_\_

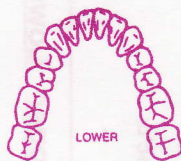


DIS. MES.



UPPER

Right Left



LOWER

Left Right

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