To: GREENFIELD DENTAL ARTS
207 Silver Street
Greenfield, MA 01301
(413) 774-7906

Dr. _____ Date _____

Street _____

City _____ State _____ Zip _____

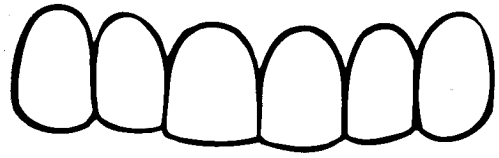
Patient _____ Time Wanted Try-In _____

Case _____ Finished _____

TEETH TO BE USED

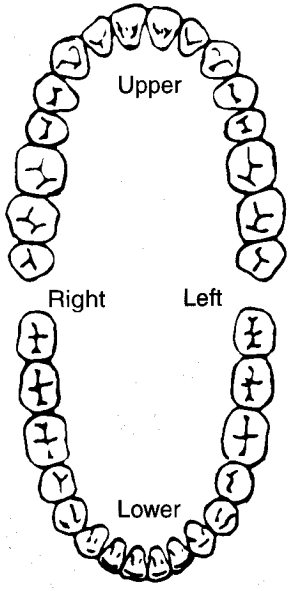
Brand _____ Shade _____ Mould _____

Type of Restoration _____



Instructions: _____

Design Case



Dentist's Signature _____

License No. _____

Tel. No. _____

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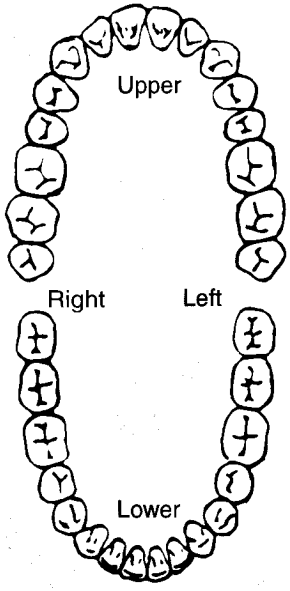

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