

DUNCAN DENTAL LABORATORY

6175 Shamrock Court - Suite A
Dublin, Ohio 43016
614-793-0330

GARY DUNCAN, B.A.
DENTAL TECHNICIAN

Patient's Name: _____

Patient's Address: _____

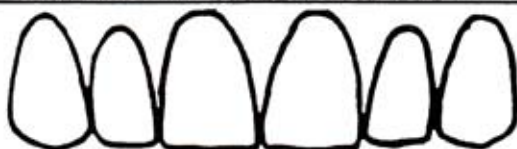
City: _____ State: _____

R_x

FOR ADDITIONAL INSTRUCTIONS, USE BACK

SHADE

GINGIVAL
INCISAL



MAKE OF TEETH

ANT
POST

DATE

HOUR

AGE _____ SEX _____

DELICATE -
 MEDIUM
 VIGOROUS -

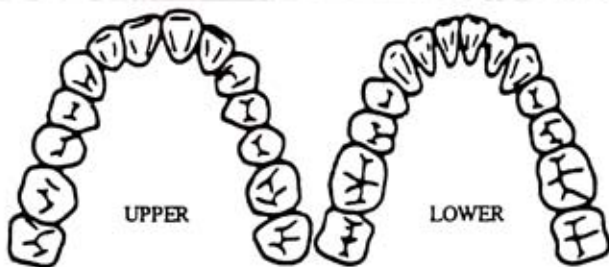
TRAYS

BITE

TRYIN

FINISH

D	H	
A	O	AM
Y	U	
	R	PM



RIGHT

LEFT LEFT

RIGHT

GOLD

dwt. _____ gr. _____

TOTAL
INVOICE \$ _____

DR. SIGNATURE

LICENSE NO.

DR. ADDRESS

PHONE NO.

DENTAL LABORATORY PRESCRIPTION