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www.renstrom.com

DOCTOR: _____ LICENSE #: _____ DATE: _____

ADDRESS: _____ RETURN DATE: _____

PATIENT NAME: _____

SEX _____ AGE _____ SHADE _____ PREP SHADE (All Ceramic) _____

CASE INSTRUCTIONS

Tooth Number:	Crown Type:
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SPECIAL INSTRUCTIONS

<p>MARGIN DESIGN</p> <input type="checkbox"/> Porcelain Shoulder <input type="checkbox"/> Buccal Band of Gold <input type="checkbox"/> No Metal to show	<p>OCCCLUSION</p> <input type="checkbox"/> Porcelain <input type="checkbox"/> Metal <input type="checkbox"/> Metal Only If Necessary	<p>PONTIC DESIGN</p> <input type="checkbox"/> Full Ridge <input type="checkbox"/> Partial Ridge <input type="checkbox"/> No Ridge <input type="checkbox"/> Convex (Socket) <input type="checkbox"/> No Contact	<p>DO YOU NEED:</p> <input type="checkbox"/> Mailing Boxes <input type="checkbox"/> Work Order Form
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Signature _____