WAKIL DENTAL LAB

(480) 740 5615

Dr. Name: _____

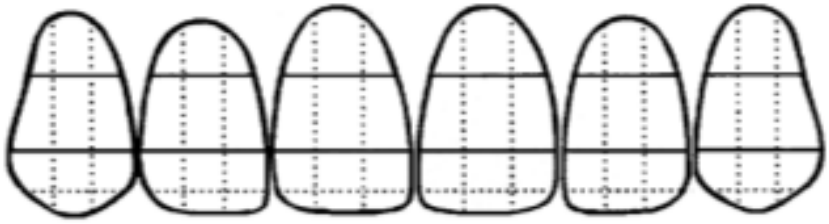
Address: _____

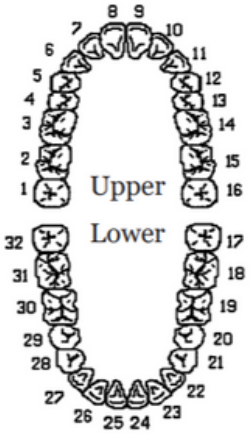
Patient Name: _____

Shade: _____

Due Date: _____

INSTRUCTIONS:





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Dr. Signature _____

Lic. # _____