DR.. _____ DATE_____

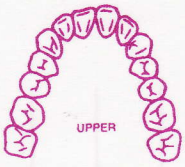
ADDRESS _____

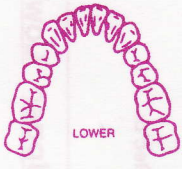
PATIENT _____ TRY-IN ❑

DATE REQUIRED _____ (X) A.M. ❑ P.M.❑

SIGNATURE _____ DDS. SHADE _____

℞





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