

PLEASE GIVE ALL NECESSARY INFORMATION



Oral Tech Dental
"Profit From Our Experience"



P.O. Box 6367 ■ Pearl, MS 39288-6367 or 121 Fairmont Plaza ■ Pearl, MS 39208
 601-939-1299 ■ 1-800-321-6201 ■ www.oraltech.com

CERTIFIED DENTAL
LABORATORY

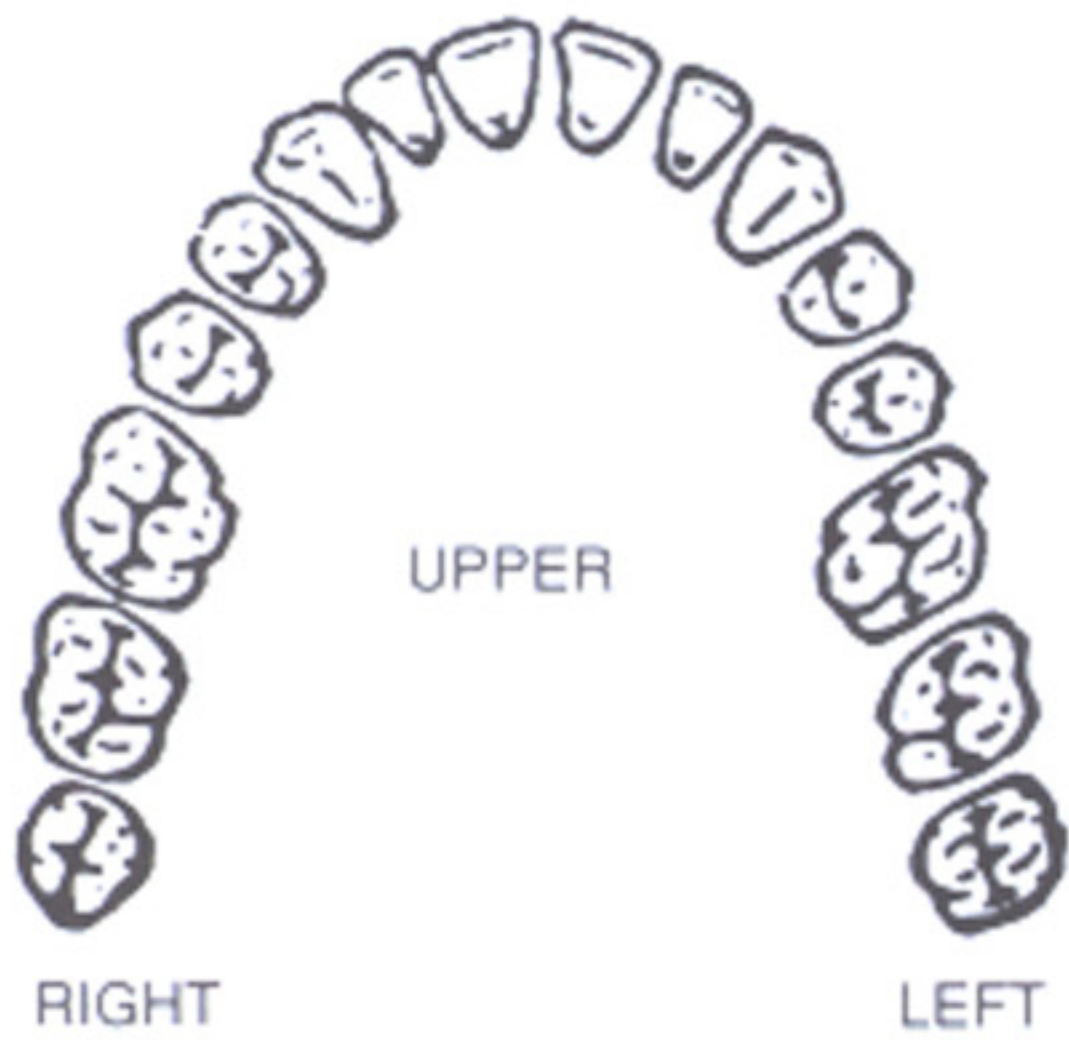
PATIENT	COMPLETE	Dr. _____
SHADE	TRIAL	Address _____
		City, State _____

PLEASE RETURN BY:

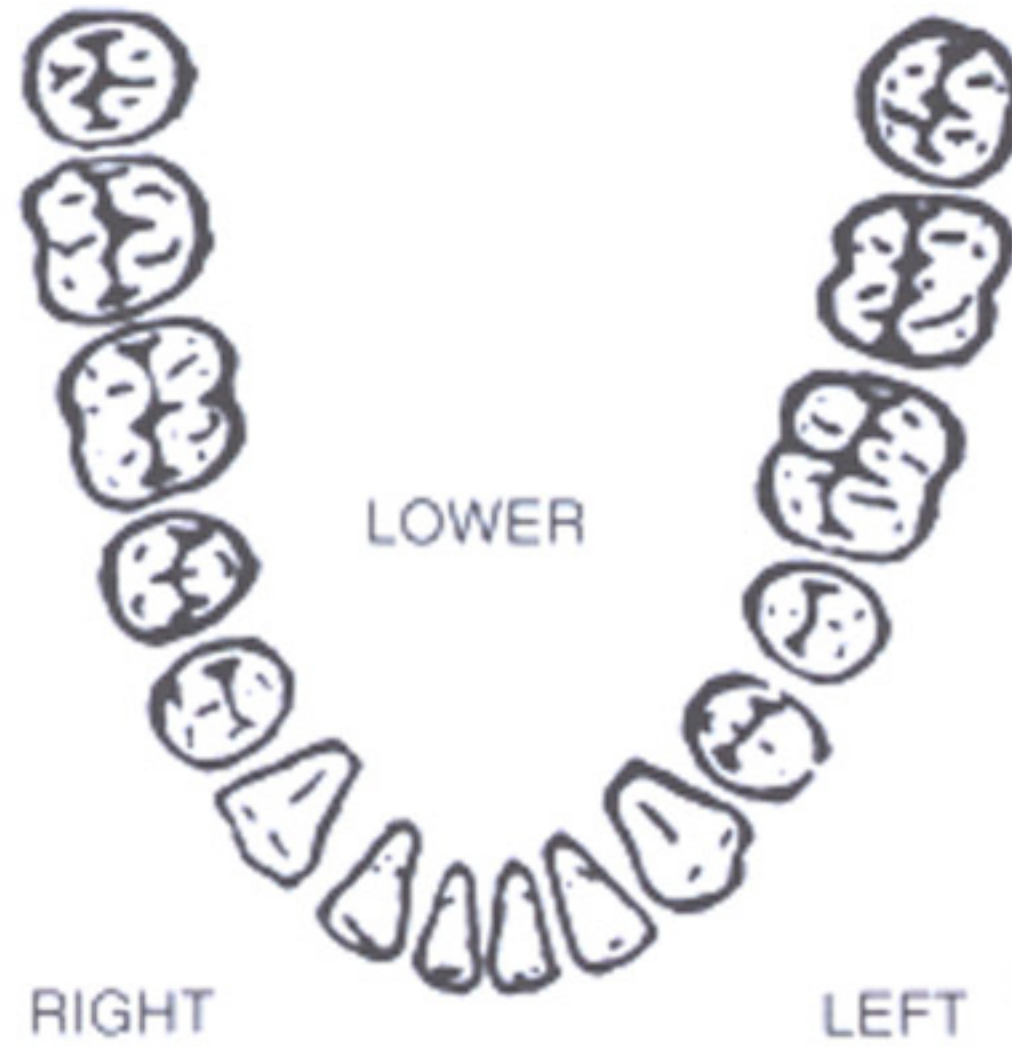
DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
DATE					

DESIGN CASE HERE

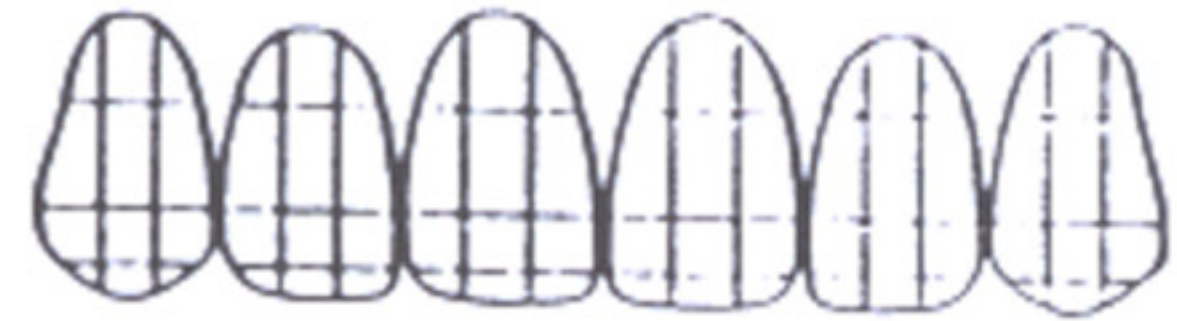
SHADE CHARACTERIZATION



UPPER



LOWER



PLEASE CIRCLE DESIRED DESIGN



SIGNATURE _____

License No. _____

**PLEASE USE OTHER SIDE
 FOR FURTHER INSTRUCTIONS THANK YOU**

Net amount of invoice is due within 30 days of receipt of order; all balances beyond 30 days are subject to a finance charge of 1.5%. I agree to pay reasonable attorneys fees and collections costs of this account is referred for collection.

FAX 601-939-4299

MARK X	
MAILING LABELS	
PRESCRIPTIONS	
MAILING BOXES	