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DR. _____ DATE _____

PATIENT'S NAME _____ SEX M ☐ F ☐ AGE _____

TYPE OF RESTORATION _____

DATE WANTED: TRY IN _____ FINISH _____

Rx

MARGIN: Metal

Porcelain
To Margin

Porcelain
Butt Margin

OCCLUSION Metal

Porcelain

Shade

