

PRECISE ORTHODONTICS

Doctor _____
Address _____
City & State _____ Zip _____
Telephone (____) _____
Patient's Name _____
Date shipped by Doctor _____
RETURN DATE _____

PLEASE PRINT PATIENT'S

NAME

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NUMBER

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DATE

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DIAGNOSTIC STUDY MODELS

- Study Models (complete)
- Study Models (complete, no soap)
- Study Models (trimmed only)
- Second Duplicate Set
- Permanent Identification
- Board Models
- Sam Articulated Models

For Lab Use

Indicate Original Malocclusion: Class _____ Division _____

ADDITIONAL INFORMATION _____

P.O. Box 633
Burlington, WI 53105
(262) 767-1440
Toll Free 1-800-517-9424

PLEASE SEND ADDITIONAL

- Shipping Boxes
- Shipping Bags/Labels
- Prescription Sheets

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