

ORTHODENT LABORATORIES

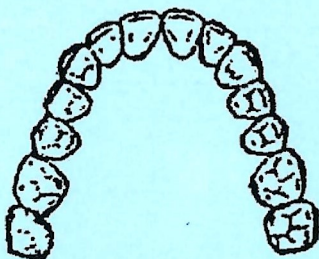
*Specialist in Orthodontic Procedures
and Functional Orthopaedics*

Doctor _____ Date Received _____

Address _____

City _____ State _____

Patient's Name _____ Age _____ Date Wanted _____



UPPER APPLIANCE

RIGHT DESIGN LEFT



LOWER APPLIANCE

Signature _____ Telephone No. _____ Date _____

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