



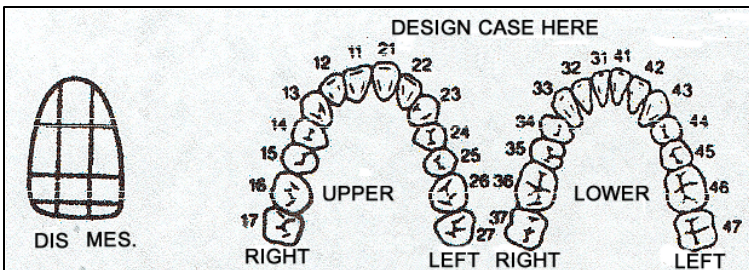
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DATE:			
DOCTOR:			
ADDRESS:			
CITY:		PROVINCE:	
PATIENT:			
AGE:		SEX:	
DATE WANTED: TRY IN:		FINISH:	
TYPE OF RESTORATION:			
INSTRUCTIONS:			



SIGNATURE: \_\_\_\_\_ D.D.S