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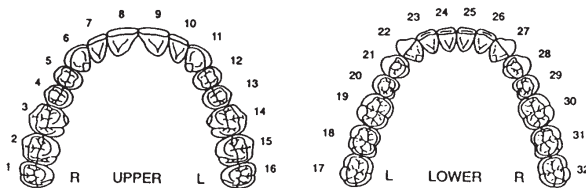
FROM _____ DATE _____
 DOCTOR _____
 ADDRESS _____ PHONE#(_____) _____
 CITY _____ STATE _____ ZIP _____
 PATIENT'S NAME _____, _____
Last NameFirst Name

<input type="checkbox"/> DELICATE	AGE	SEX	SHADE	MOULD
<input type="checkbox"/> MEDIUM				
<input type="checkbox"/> VIGOROUS				

DATE WANTED	TIME	AM
		PM

<input type="checkbox"/> Try In	<input type="checkbox"/> Finish	<input type="checkbox"/> Custom Tray	<input type="checkbox"/> Occlusion Rim
<u>CHECKLIST</u>		<u>ANTERIOR SET-UP</u>	
<input type="checkbox"/> Midline Marked		<input type="checkbox"/> Ideal	
<input type="checkbox"/> High Lip Line - Marked		<input type="checkbox"/> Characterized	
<input type="checkbox"/> Proper Lip Support		<input type="checkbox"/> Study Model	

RX SPECIFIC INSTRUCTIONS:



SIGNATURE _____

LICENSE NUMBER _____

Bills are due and payable by the 10th of the month following billing. All bills not paid in full within 30 days following month of billing will carry a 1 1/2% per month service charge.