MAIL ON ______________________________

8740 SW SCOFFINS ST.
TIGARD, OREGON 97223
(503) 656-2775
FAX (503) 656-2120
1-800-595-3495
www.cdppdx.com

FROM DATE ______________________

DOCTOR ____

ADDRESS ______________________________ PHONE#(_____) ______________

CITY ______________________ STATE__________ ZIP ______________

PATIENT'S NAME ______________________, ______________________
Last Name First Name

☐ DELICATE ☐ MEDIUM ☐ VIGOROUS	AGE	SEX	SHADE	MOULD

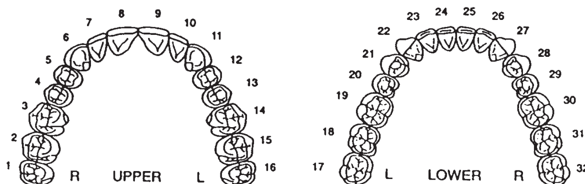
DATE WANTED	TIME	AM PM

☐ Try In ☐ Finish ☐ Custom Tray ☐ Occlusion Rim

CHECKLIST
- ☐ Midline Marked
- ☐ High Lip Line - Marked
- ☐ Proper Lip Support

ANTERIOR SET-UP
- ☐ Ideal
- ☐ Characterized
- ☐ 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.