



5225 E. Main Street
Columbus, Ohio 43213
614-759-6747



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Columbus, Ohio 43213
614-759-6747

DATE _____

DOCTOR _____

ADDRESS _____

CITY AND STATE _____

PATIENT _____

TYPE OF APPLIANCE _____

DATE WANTED _____

DATE _____

DOCTOR _____

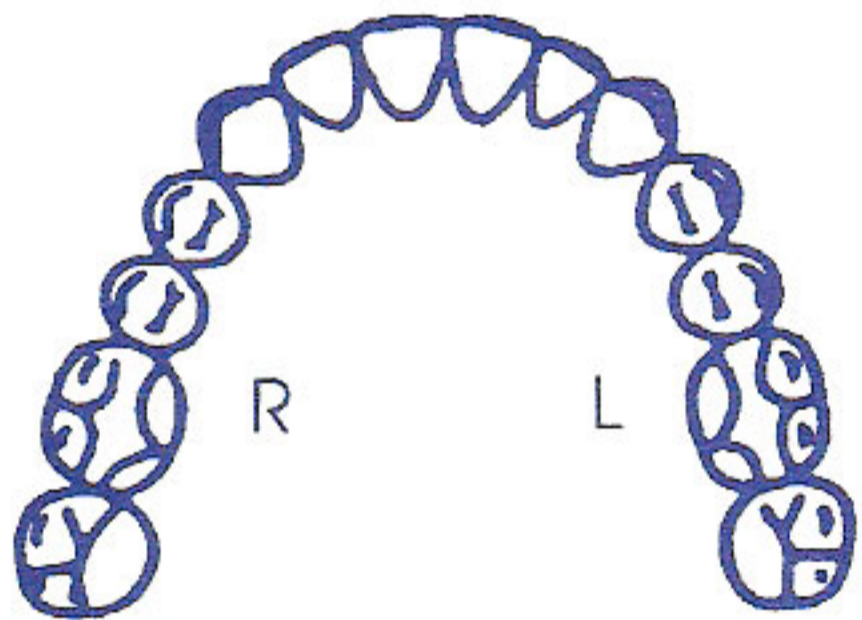
ADDRESS _____

CITY AND STATE _____

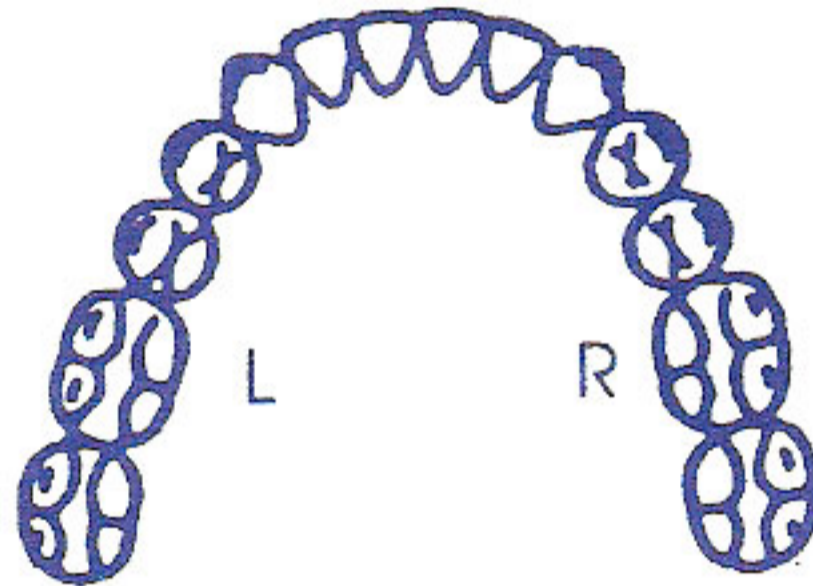
PATIENT _____

TYPE OF APPLIANCE _____

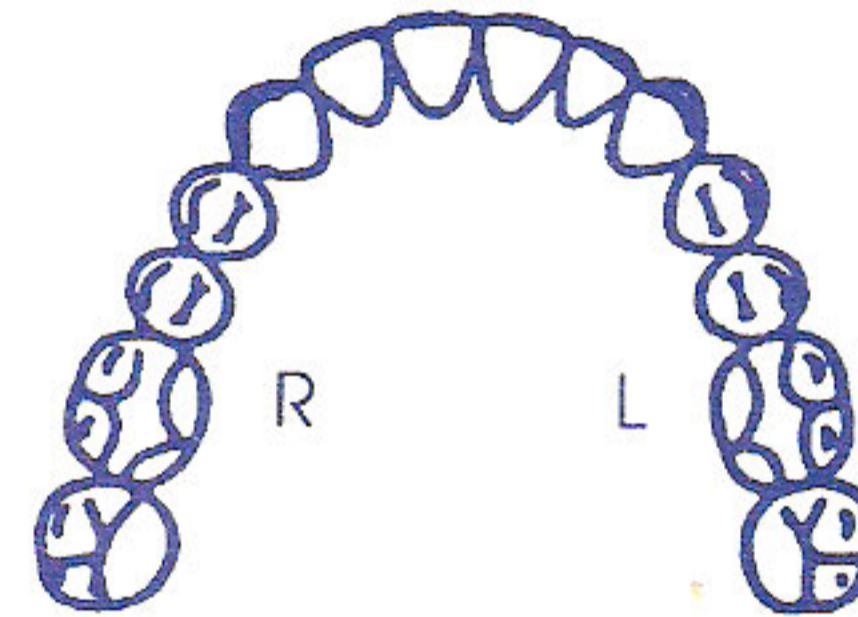
DATE WANTED _____



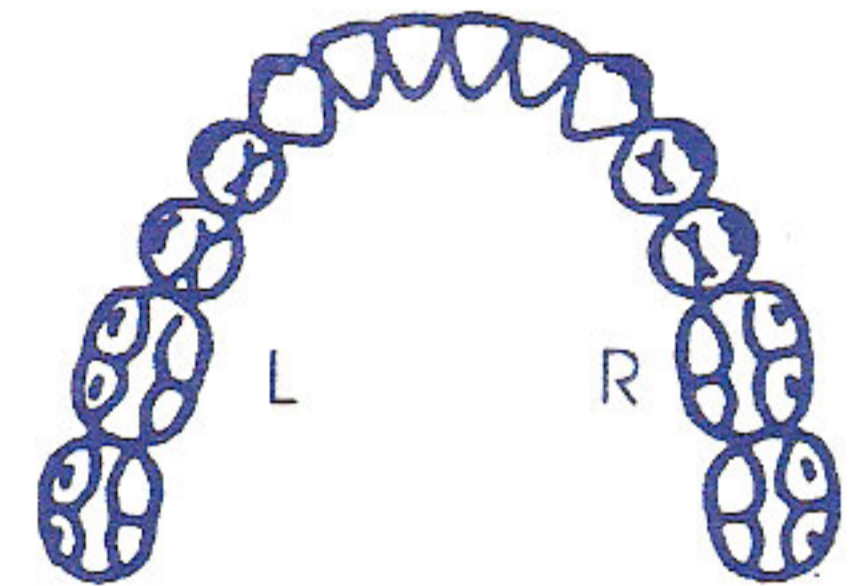
UPPER



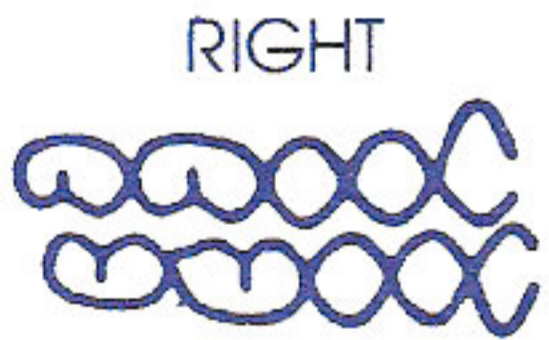
LOWER



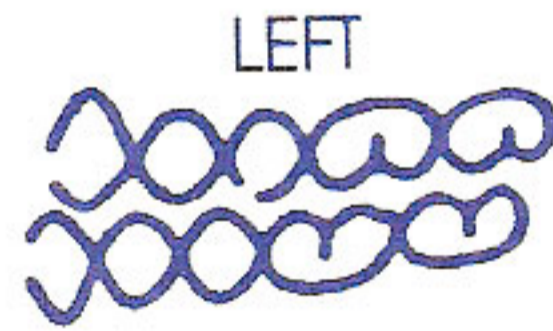
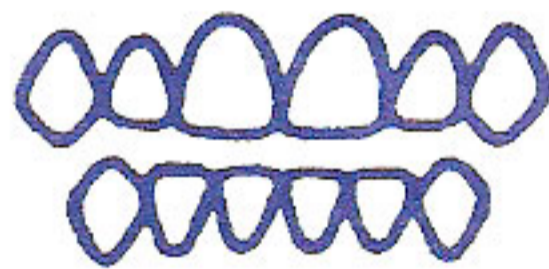
UPPER



LOWER

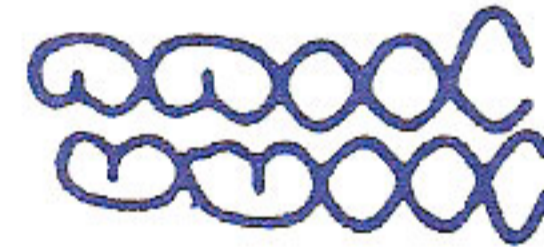


RIGHT

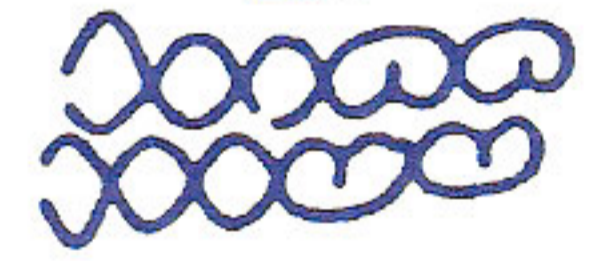
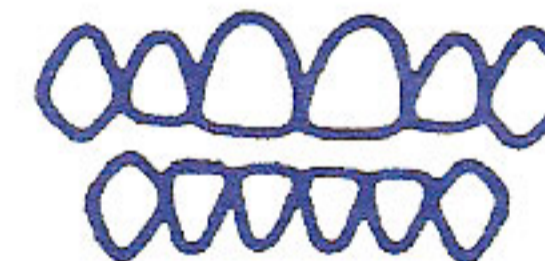


LEFT

APPLIANCE DESIGN



RIGHT



LEFT

APPLIANCE DESIGN

INSTRUCTIONS (USE OTHER SIDE IF NECESSARY)

INSTRUCTIONS (USE OTHER SIDE IF NECESSARY)

SIGNATURE _____ D.D.S.

LICENSE NO. _____

(OVER)

SIGNATURE _____ D.D.S.

LICENSE NO. _____

(OVER)