Diamond Dental Studio

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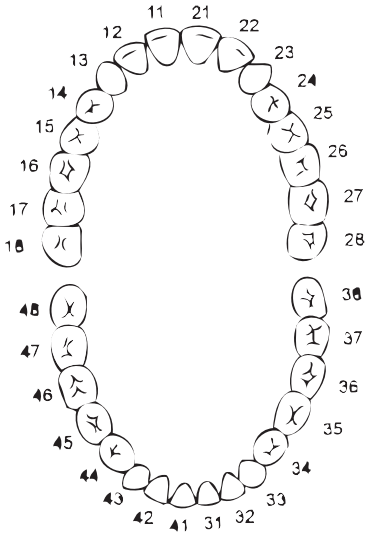
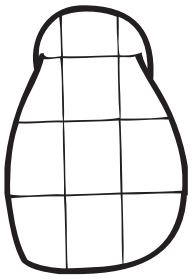


DATE REQUIRED: _____ **TIME:**_____

Doctor's Name: _____ Tel:_____



Patient: _____

SEX: _____ AGE: _____

Shade: _____

INSTRUCTIONS:

Doctor's Signature: _____ **Date:** _____