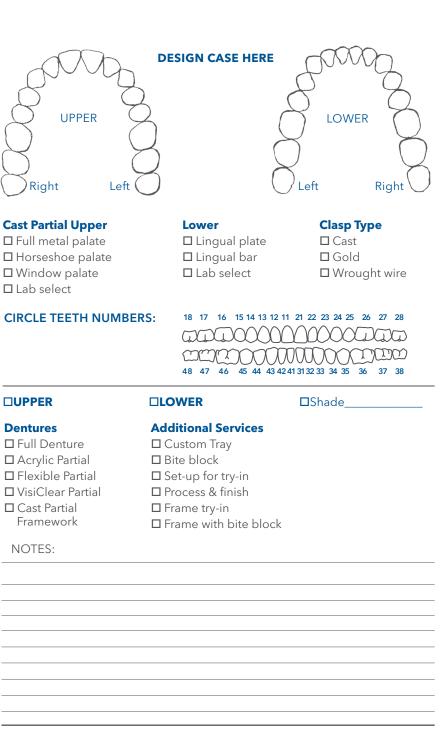


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Removable Prosthetics Rx

RX DATE
CASE #
DATE WANTED TIME
DOCTOR INFORMATION
Name
Address
Telephone
PATIENT INFORMATION
Name Sex Age
Have You Included The Following: □ Impression □ Bite □ Opposing □ Shade □ Pre-op study model
Checklist □ Midline marked □ High lipline marked
Please Send □ Prescription Forms □ Plastic bags □ Case boxes
Rx



Doctor's Signature

License #