



Perfect
Touch
Lab

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DOCTOR _____ PATIENT _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE _____

DOCTOR'S SIGNATURE _____ LICENSE NUMBER _____

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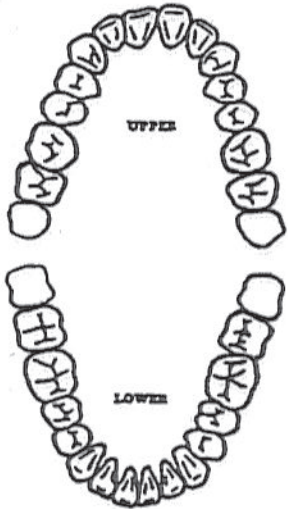
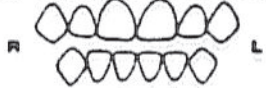
STATE _____ ZIP _____ PHONE _____

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INSTRUCTIONS

COLOR _____ DATE WANTED _____

STRIP AND RESET TEETH MARKED



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COLOR _____ DATE WANTED _____

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