



# DENTAL ARTS

ORTHODONTIC LABORATORY

1600 S. Anaheim Blvd., Suite C • Anaheim, CA 92805

(714) 635-2008 • FAX (714) 635-3396

SM	
APPL	
MB	
T	

Doctor \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DUE DATE \_\_\_\_\_ Chair time \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

## PATIENTS NAME

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_

Yrs.

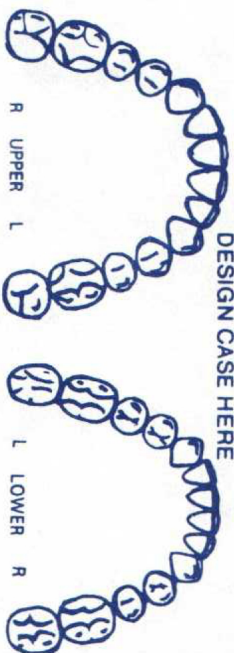
Mos.

AGE: \_\_\_\_\_

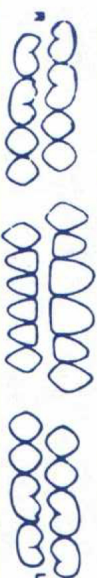
CASE NO: \_\_\_\_\_

\_\_\_\_\_

STUDY MODELS: ☐ Finished ☐ Semi-Finished ☐ Trim Only ☐ Duplication



ACRYLIC COLOR



## NOTES:

All appliances are warranted for **60 days** from date manufactured.  
Office will be responsible for accuracy of working cast.  
Please send white and yellow copies to laboratory, retain pink copy for



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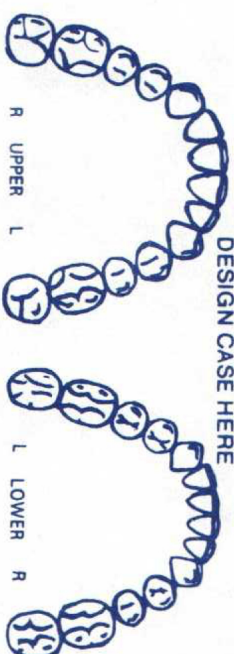
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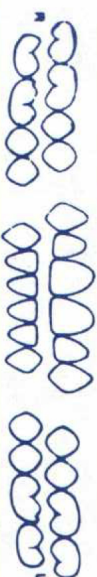
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