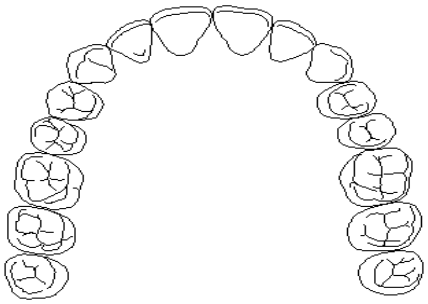
RX DATE:_____**DUE DATE**: _____**Deliver By 5:00 PM**

DOCTOR'S NAME:_____(Please Print)

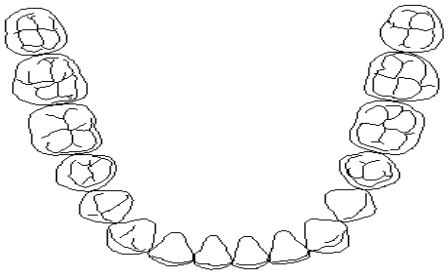
DOCTOR'S ADDRESS:_____**PHONE**:_____

PATIENT'S NAME:_____

SHADE DESIRED:_____ **TISSUE SHADE**:_____



UPPER



LOWER

CASE INSTRUCTIONS:

_____

_____

_____

_____

_____

_____

Dr. License# _____

2960 BUSH DR. MELBOURNE, FL 32935 PHONE: 321.610.7372 FAX: 321.752.4274