CREHS Inc

DIGITAL SOLUTIONS
IN HEALTH SERVICES

Doctor's Name:____Date:_________________

Address:____

Patient:____Age:_____________________ M☐ F☐

DUE DATE:____

ALL CERAMIC

FULL ZIRCONIA
E-Max
Porcelain Veneer

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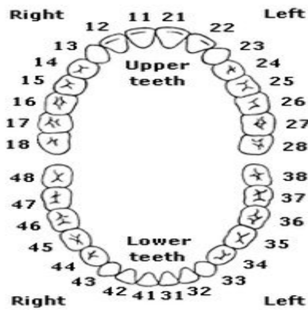
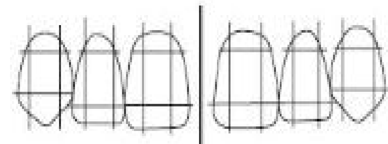
Shade:



Neck:
Body:
Incisal:



Signature:____________________________

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