TO

A&J Dental Lab

106 West Palisade Avenue
Englewood, NJ 07631
Telephone: (201) 569-0775
Cell: (201) 952-4504

FROM

WORK ORDER NUMBER_____ DATE_____

DR. _____

ADDRESS _____

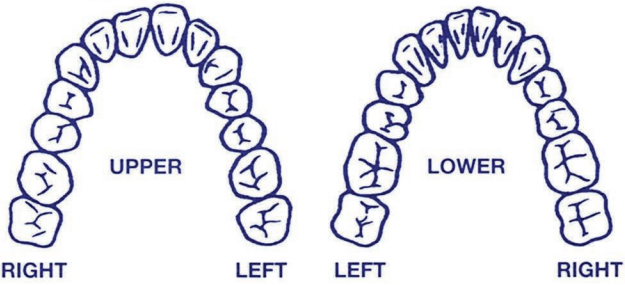
CITY_____ STATE_____ ZIP_____

PATIENT'S NAME OR IDENTIFICATION NUMBER _____

TYPE OF RESTORATION _____

DATE WANTED: TRY-IN_____ AM PM FINISH_____

(CONSTRUCT AND DELIVER TO THE UNDERSIGNED ONLY THE HEREIN DESCRIBED DENTAL RESTORATION.)



	ANTERIOR		POSTERIOR	
UPPER	SHADE	MOULD	SHADE	MOULD
LOWER	SHADE	MOULD	SHADE	MOULD

INSTRUCTIONS

FINISH CASE IN: ❑ CHARACTERIZED LUCITONE® ❑ LUCITONE 199®

DENTIST LICENSE NUMBER_____ DATE_____

_____

PERSONAL SIGNATURE OF DENTIST