# RX FORM

Dr/Practice: ____________________

Address: ____________________

Phone: ____________________

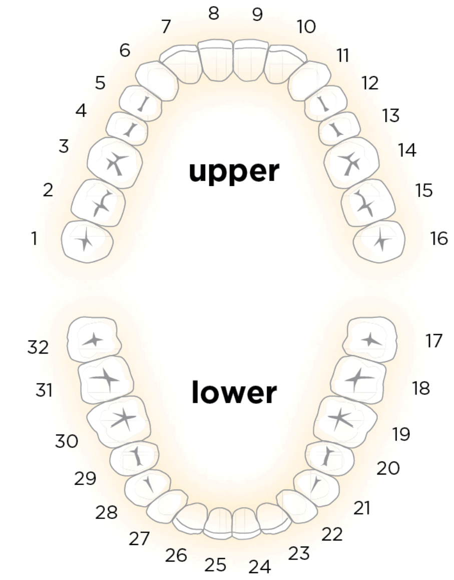
**Patient Name:** ____________________

**RX Date:** ____________________

**Dr. Signature:** ____________________

**License #:** ____________________

**Permanent Teeth Diagram**




Shade: ____________________

**COMMENTS**

**Posterior:** ZSolid, **Anterior:** ZAnterior

**Enclosures** ☐ Photo(s) ☐ Impression ☐ Models ☐ Bite Other:

**Shipping** ☐ Standard $7 ☐ 2nd Day $10 ☐ Next Day $20

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