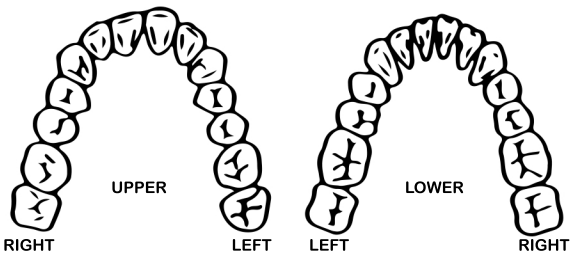
DENTAL PROSTHETIC PRESCRIPTION

TO: ADL Albany Dental Lab	DATE SENT:
	TRY-IN:
	FINISH:
FROM: DR.	MATERIAL:
STREET:	SHADE:
CITY: STATE:	MOULD:
PATIENT:	TYPE OF CASE:

COMPLETE DESCRIPTION

Rx



SIGNED DR. _____

DENTIST'S LICENSE NO._____ DATED THE_____ DAY OF_____

ALBANY DENTAL LABORATORY

P.O. BOX 344
ALBANY, GEORGIA 31702
JOHN COLLIN HEATH
(229) 436-7795
1-800-392-1822