PCM DENTAL LAB

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(808)336-0285 pcmlab2008@gmail.com

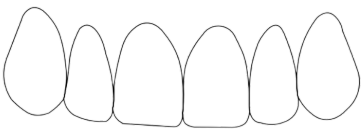
Dr/ Practice _____

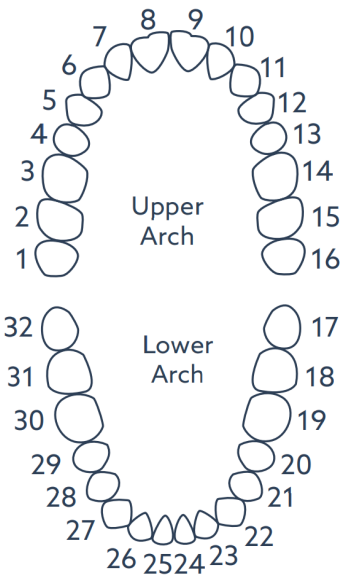
Patient Name _____ ☐ Male ☐ Female

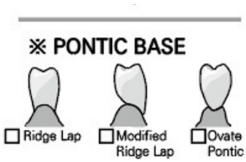
Due Date / /

Impression ☐ Digital ☐ Analog

Shade:







Rx Specific Instructions

Signature_____

License# DT-_____