

PLEASE GIVE ALL NECESSARY INFORMATION



Great Southwest Dental Laboratory
 "Building Knowledge Based Relationships"

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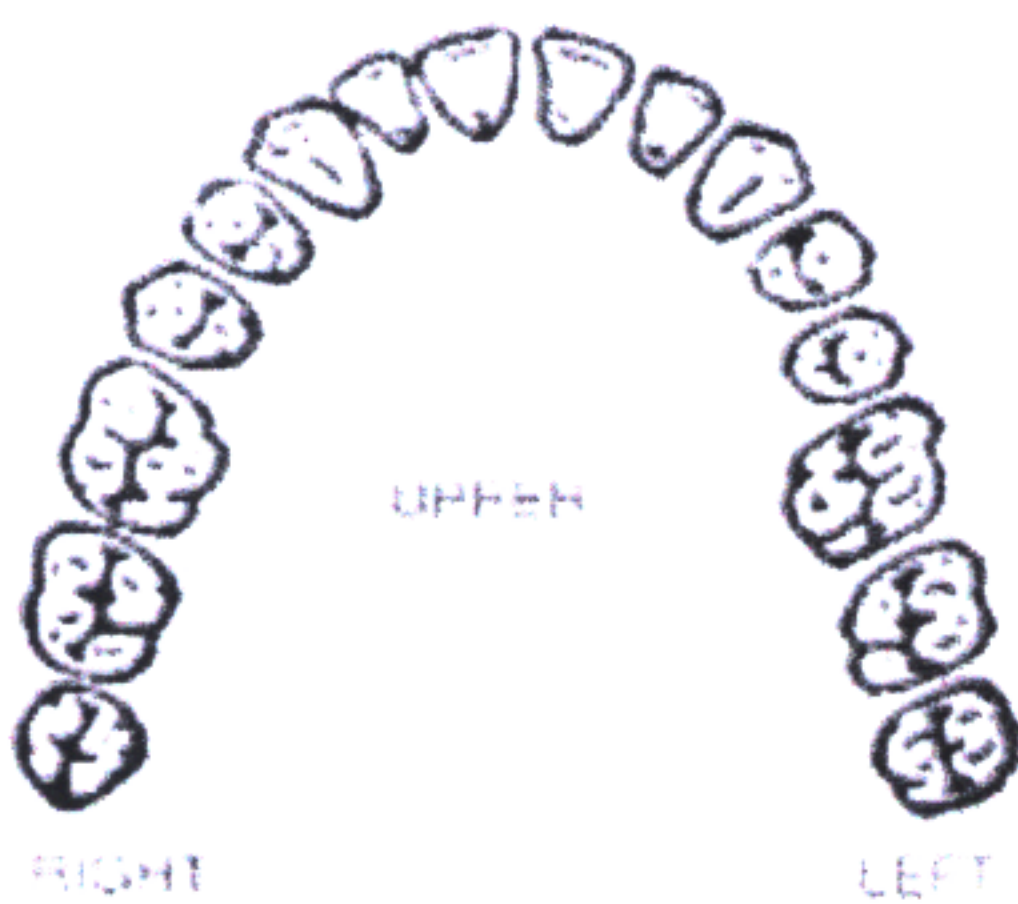
PATIENT	COMPLETE	Dr. _____
SHADE	TRIAL	Address _____
		City, State _____

PLEASE RETURN BY:

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
DATE					

DESIGN CASE HERE

SHADE CHARACTERIZATION



PLEASE CIRCLE DESIRED DESIGN



SIGNATURE _____

License No. _____

PLEASE USE THE OTHER SIDE FOR FURTHER INSTRUCTIONS...THANK YOU!

FAX 405-787-4525

