KAZ RDT
DENTAL LABORATORY LLC

A MEMBER OF ACP
AMERICAN COLLEGE OF PROSTHODONTISTS

Dr._____ Date:_____

Patient name:_____ Age:_____

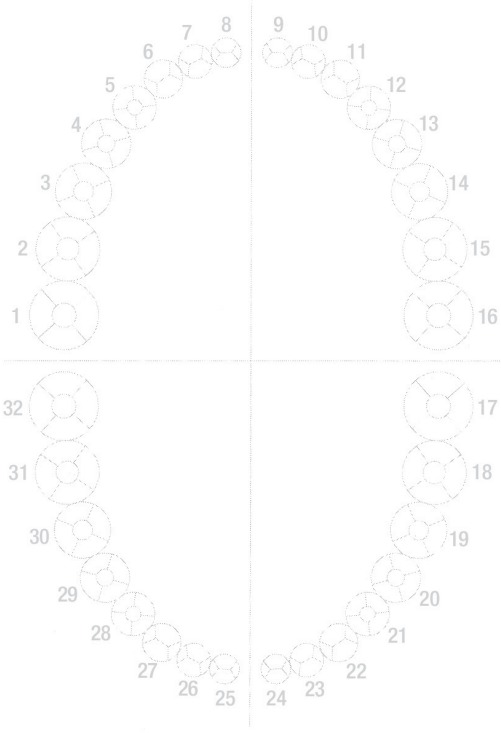
Male: ☐ Female: ☐

Type Of Restoration _____ Tooth #:_____

Due Date:_____ Try In: ☐ Due Date:_____ Finish: ☐

Remarks:_____ Shade: _____

Value	Hue	Chroma



Signature_____ Lic.#:_____