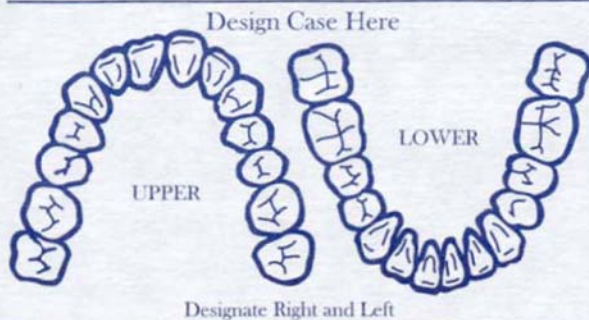


DENTAL LABORATORY WORK AUTHORIZATION



No 000

Doctor _____ Date _____



Patient _____

Appliance Type _____

Date Wanted _____

Please print or write legibly and mai

ossible. Use reverse side if necessary.

Signature _____ D.M.D.

D.D.S.

Address _____

Dental License No. _____

Please Send Additional:

Prescription Forms

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