



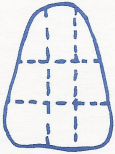
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DOCTOR \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE \_\_\_\_\_ DATE REQUIRED \_\_\_\_\_

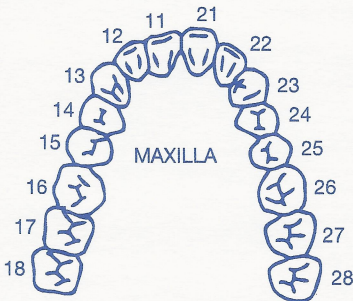
PATIENT \_\_\_\_\_ SEX M  F  AGE \_\_\_\_\_



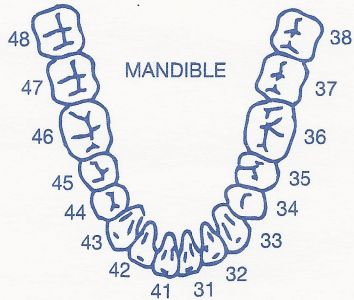
CHARACTERIZATION  
AND SHADE



CHART FOR STAINING



MAXILLA



MANDIBLE

Signature \_\_\_\_\_ DDS