Sunflower
DENTAL STUDIO

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Topeka, Kansas 66605
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techs@sunflowerdentalstudio.com

No.

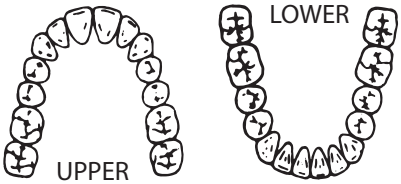
ROY GOODEN ERIC GOODEN AARON HOFFMAN

Doctor _____ D.M.D. D.D.S.
(please print)

Dental License No._____ Date _____

Address _____

DESIGN CASE HERE



DESIGNATE RIGHT AND LEFT

☐ Photos have been emailed
☐ Photos have been texted
☐ Pt. to come to lab for shade

Patient _____

Age _____ Sex M F

Restoration _____

_____

Shade _____

Material _____

_____

Date Wanted_____

Patient is scheduled on ___/___/___ at ___:___ AM* PM

*failure to provide this information could lead to scheduling complications

Please print or write legibly and make instructions as complete as possible. Use reverse side if necessary.

Signature _____ D.M.D. D.D.S.

MUST BE RETAINED BY DENTAL LABORATORY FOR 2 YEAR

STUDIO NOTES: LAB USE ONLY