

# Flex Dental Laboratory

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DENTIST: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

CASE/TYPE: \_\_\_\_\_ SHADE/MOULD: \_\_\_\_\_

SPECIAL TRAY: \_\_\_\_\_ MMR / BITE: \_\_\_\_\_

TRY-IN: \_\_\_\_\_ RE-TRY: \_\_\_\_\_

FINISH: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

INSTRUCTIONS:

