



MOSS Dental Lab, Inc.

2736 Ring Road • Elizabethtown, Kentucky 42701


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Email: mossdentallab@yahoo.com

LABORATORY PRESCRIPTION FROM:

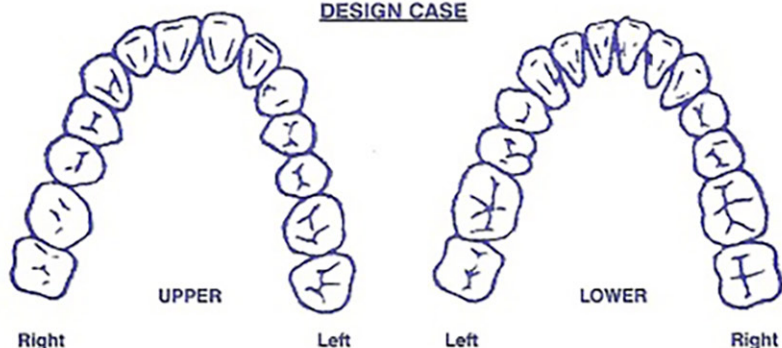
DR. _____

PATIENT _____

TIME WANTED TRY-IN	FINISH	
SPECIAL SHADE INSTRUCTIONS 	SHADE	GINGIVAL
		INCISAL
	Age _____ Sex _____	

R

DESIGN CASE



DENTIST'S SIGNATURE _____

LICENSE NO. _____ DATE _____

Delivery slip and invoice must have patient name and/or number