CRAWFORD'S ORTHODONTIC SERVICE

DUE DATE _____

TIME _____

DR. _____ DATE _____

ADDRESS _____ CITY _____

STATE_____ ZIP _____ PHONE NO. _____

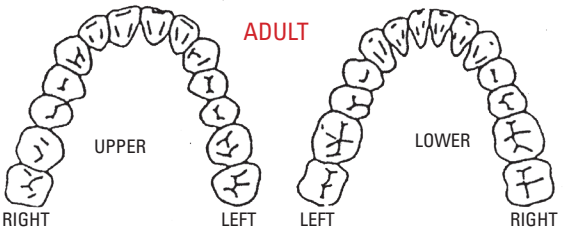
PATIENTS NAME_____ AGE _____

TOOTH SHADE ____

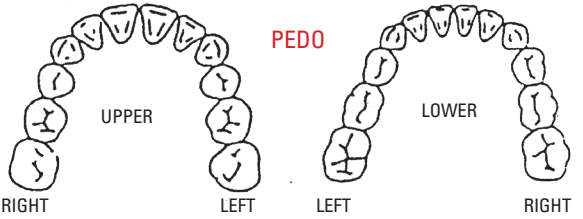
YOUR CASE DESIGN

Rx

ADULT



PEDO



WE NEED:

☐ PRESCRIPTION SLIPS

SIGNATURE _____ LIC. NO. _____

1845 WEST 4400 SOUTH #301 ROY, UTAH 84067
(801) 731-3519 www.crawfordlab.com