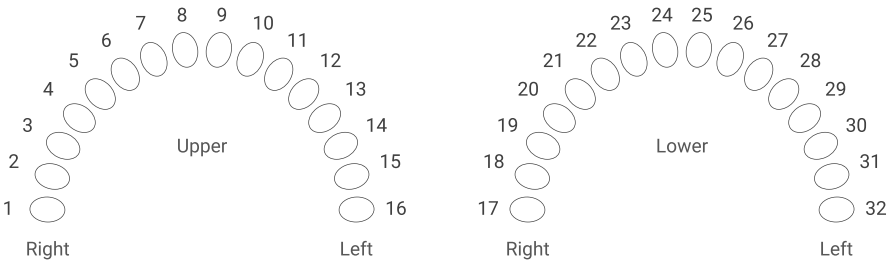




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Miami, FL 33186

Doctor	Today	mm/dd/yyyy	
Street address	Appt.	mm/dd/yyyy	
City, State ZIP			
Patient	Male	<input type="checkbox"/>	Female <input type="checkbox"/>
Tooth shade	Tryin	<input type="checkbox"/>	Finish <input type="checkbox"/>
Gingival shade	TP	<input type="checkbox"/>	LP <input type="checkbox"/>
	OP	<input type="checkbox"/>	RP <input type="checkbox"/>
			DP <input type="checkbox"/>



Lic. No. _____ Signature _____