CLARK DENTAL LAB

(816) 765-1517
13016 Sixth Street • PO Box 243
Grandview, MO 64030

Prescription No. _____ Date _____

Name &/or Number of Patient _____

Type of Case _____ **SHADE** _____

TIME WANTED _____ Please indicate unless normal 7-day service is satisfactory.

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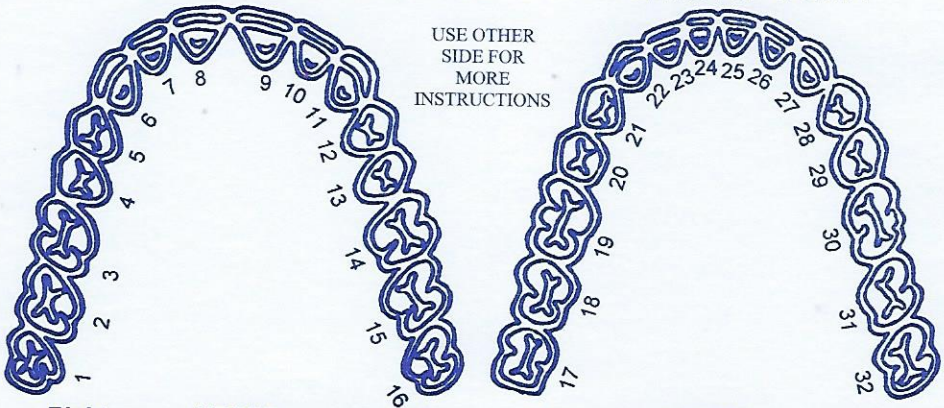
STOP! HAVE YOU FORGOTTEN TO MARK SHADE OF TEETH?



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Signature of Dentist License No.

Do you need more mailing material? If so, check what is wanted:

❑ **LABR. ORDER BLANKS** ❑ **STICKERS**