



orthodent toronto

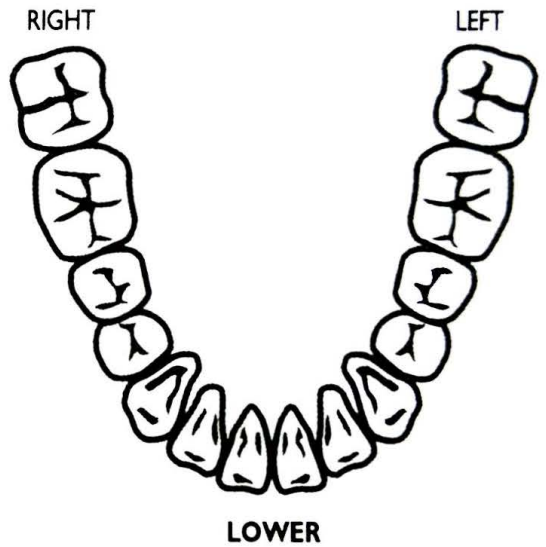
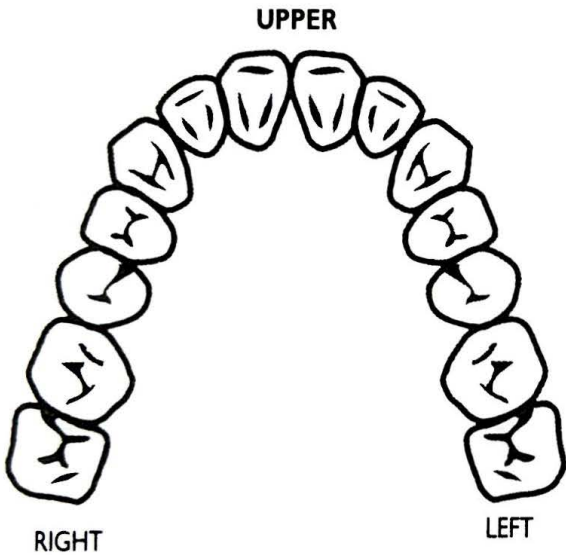
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Dr. _____ Date _____

Address _____

Patient _____ Age _____

Date Wanted _____ Time _____



INSTRUCTIONS *Please use reverse if necessary*

Signature _____