LABORATORY PROCEDURE AUTHORIZATION

To: Ortho Pro-Tech Dental Laboratory
Florida Dental Lab Reg. # 02657
2110 Sylvester Rd. STE # 3
Lakeland, FL 33803
863-802-8622
juanorthopro@gmail.com

Patient Name: _____

Date Sent: _____

Finish (in office) Date: _____

COMPLETE DESCRIPTION

Rx:

Dr. Signature: _____ Lic#

(Printed) Dr._____

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