



CINCO RANCH ORTHODONTIC LABORATORY
1402 GREENBUSCH, SUITE 1400
KATY, TEXAS 77494
281-395-0322 or 832-526-6268
www.cincoranchlab.com

PATIENT NAME: _____

TODAY'S DATE: _____

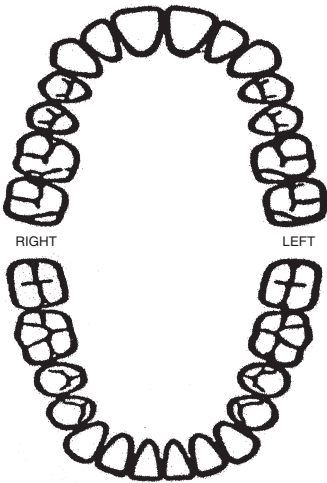
DUE DATE: _____

DR. _____ PHONE # _____

Due date will be the date this case is due from the lab. Five days minimum are required in the lab.

Design Area:

Special Instructions:



Acrylic Color:

LICENSE #: _____

DR. SIGNATURE _____

A doctor's signature is required to validate this prescription. By signing you also agree to payment of any and all charges as applied to this prescription. Please see the brochure for more information regarding fees. Your business is greatly appreciated.