

4511 S.E. Hawthorne Blvd., Suite 217  
Portland, Oregon 97215 • (503) 231-6098

DATE \_\_\_\_\_

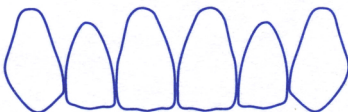
PATIENT \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

**FINISH DATE**

**TIME**

**LAB USE ONLY**

SHADE \_\_\_\_\_



(CONT'D OVER)

DR. SIGNATURE

LICENSE NO.

DR. ADDRESS

PHONE NO.