Kapás Dentart Kft.

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Dentist Name: _____

Due Date: _____

Patient Name: _____

Age: _____ ,

Sex: ◯ Male / ◯ Female

Type: △ ○ □

Shade: _____

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	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

- ○ CoCr
- ○ Zirconia
- ○ Acryl
- ○ Composite

- ○ Press
- ○ e.Max
- ○ Temporary
- ○ Implant

Note: