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CHAIN O' LAKES
DENTAL LABORATORY

37669 North Rt. 59, Lake Villa, IL 60046
847-973-8734 | coldentallab@gmail.com
www.coldentallab.com

FROM
Dr. _____

Address _____

City _____ **State** _____

Patient's Name _____ **Indentification or Number** _____

(Construct and deliver to the undersigned only, the herein described dental restoration)

INSTRUCTIONS:

SHADE _____ **MALE** ☐ **FEMALE** ☐ **TRY IN** _____

DENTIST'S LICENSE NUMBER: _____ **Date Wanted** _____

Dated: The _____ **day of** _____ **, 20** ____

_____

(Personal signature of dentist)
(In compliance with Illinois Dental Practice Act.)