

**Rodney Frie, CDT**

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**CLINIC INFORMATION**

Prescribing Doctor : \_\_\_\_\_

Clinic Name / Location : \_\_\_\_\_

Assistant Contact : \_\_\_\_\_

**PATIENT INFORMATION**

\*Date Prescribed : \_\_\_\_\_

\*Patient Name : \_\_\_\_\_

\*Patient DOB : \_\_\_\_\_

\*Appliance (Upper): \_\_\_\_\_

Color Requested (Upper): \_\_\_\_\_

\*Appliance (Lower): \_\_\_\_\_

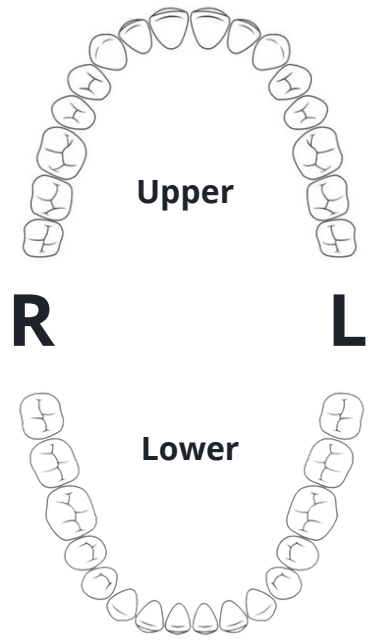
Color Requested (Lower): \_\_\_\_\_

\*Date Requested : \_\_\_\_\_

(One day prior to appointment date)

Special Instructions (If Needed) : \_\_\_\_\_

\_\_\_\_\_



**X** \_\_\_\_\_

\*Prescribing Doctor Signature

\*License Number

\*Denotes items required by Texas Law to fulfill prescription.

**LAB USE ONLY**

REC : \_\_\_\_\_ COMP : \_\_\_\_\_ DEL : \_\_\_\_\_

LAB NOTES : \_\_\_\_\_

\_\_\_\_\_

Send White and Yellow Copies with the case to the Lab -- KEEP PINK COPY ONLY