






DENTAL SURGEON _____
 ADDRESS _____

 POSTCODE _____
 TELEPHONE NO. _____
 EMAIL _____




PATIENT'S NAME _____
 (Block Capitals only)
 DATE _____ DATE REQUIRED _____
 (Allow 5 full working days to construct)
 DELIVERY ADDRESS IF DIFFERENT _____

RANGE OF JEWELLERY (Tick one box)







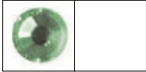



STAR form

				
S1 Clear Glass	S2 Topaz Blue	S3 Orange	S4 Ruby	S5 Spinel Blue

ROUND form

		
R1 Transparent	R2 Ruby	R3 Spinel Blue


ROSE form

				
R11 Clear Glass 2.5mm diameter	R12 Clear Glass 2.0mm diameter	R13 Pale Pink 2.5mm diameter	R14 Pale Pink 2.0mm diameter	R15 Light Blue 2.5mm diameter
				
R16 Light Blue 2.0mm diameter	R17 Light Green 2.5mm diameter	R18 Light Green 2.0mm diameter	R19 Light Siam 2.5mm diameter	R20 Sapphire 2.5mm diameter

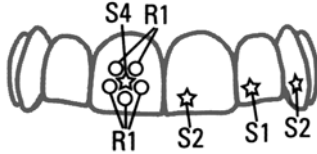
YOUR SPARKLING SMILE

Please accurately mark the position of where you want the jewels or gems positioned on each tooth.

Indicate which jewel or gem you require by using the 3 digit code (see example).



Example:



CHECKLIST – Please enclose

<input type="checkbox"/> Upper and lower Alginate Impressions/Models	<input type="checkbox"/> Prescription form completed by dentist and patient	<input type="checkbox"/> Payment
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STATIONERY

Please indicate how many of the following you require:

<input type="checkbox"/> Handouts	<input type="checkbox"/> Posters	<input type="checkbox"/> Freepost Labels
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