

Tandlæge: _____

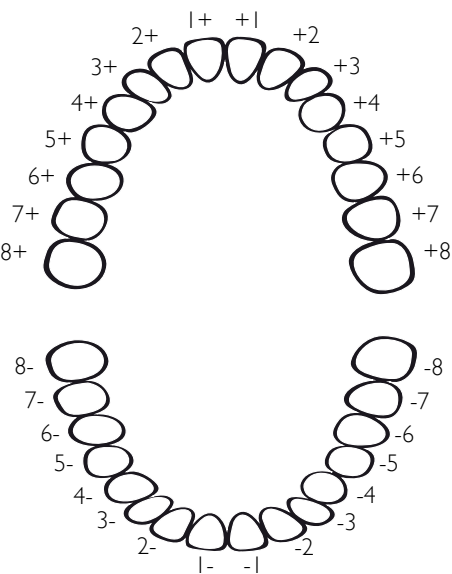
Patient: _____

CPR: _____

Færdig den: _____ dag ____ / ____

Afsendt/aflev. den: _____

Kl: _____



- | | OK | UK |
|-----------------------------|--------------------------|--------------------------|
| Ske | <input type="checkbox"/> | <input type="checkbox"/> |
| Plastron | <input type="checkbox"/> | <input type="checkbox"/> |
| Duplikering | <input type="checkbox"/> | <input type="checkbox"/> |
| Rebasering | <input type="checkbox"/> | <input type="checkbox"/> |
| Unitor | <input type="checkbox"/> | <input type="checkbox"/> |
| Opst. Partiel Protese | <input type="checkbox"/> | <input type="checkbox"/> |
| Opst. Hel Protese | <input type="checkbox"/> | <input type="checkbox"/> |
| Færdiglavning | <input type="checkbox"/> | <input type="checkbox"/> |

Tandfarve: _____

Tandform: _____

Faveskala: _____

Medsendt: _____

Deers Dental tlf: 26 84 05 43

Tandlæge: _____

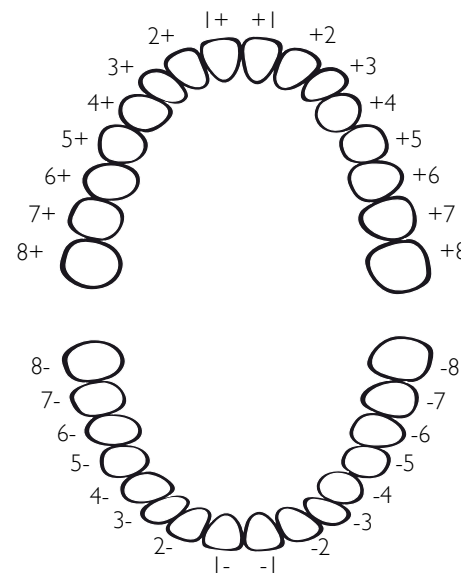
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