



SOL

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DATE / TIME DUE:

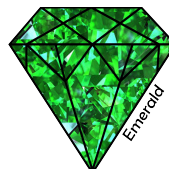
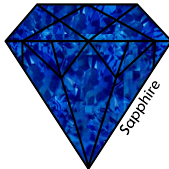
Address:

Phone:

JEM MOUTHGUARD LAB SHEET

PATIENT NAME: _____

PATIENT PHONE No. _____



TRIPLE

DUAL

SINGLE

COLOUR:



Signature _____