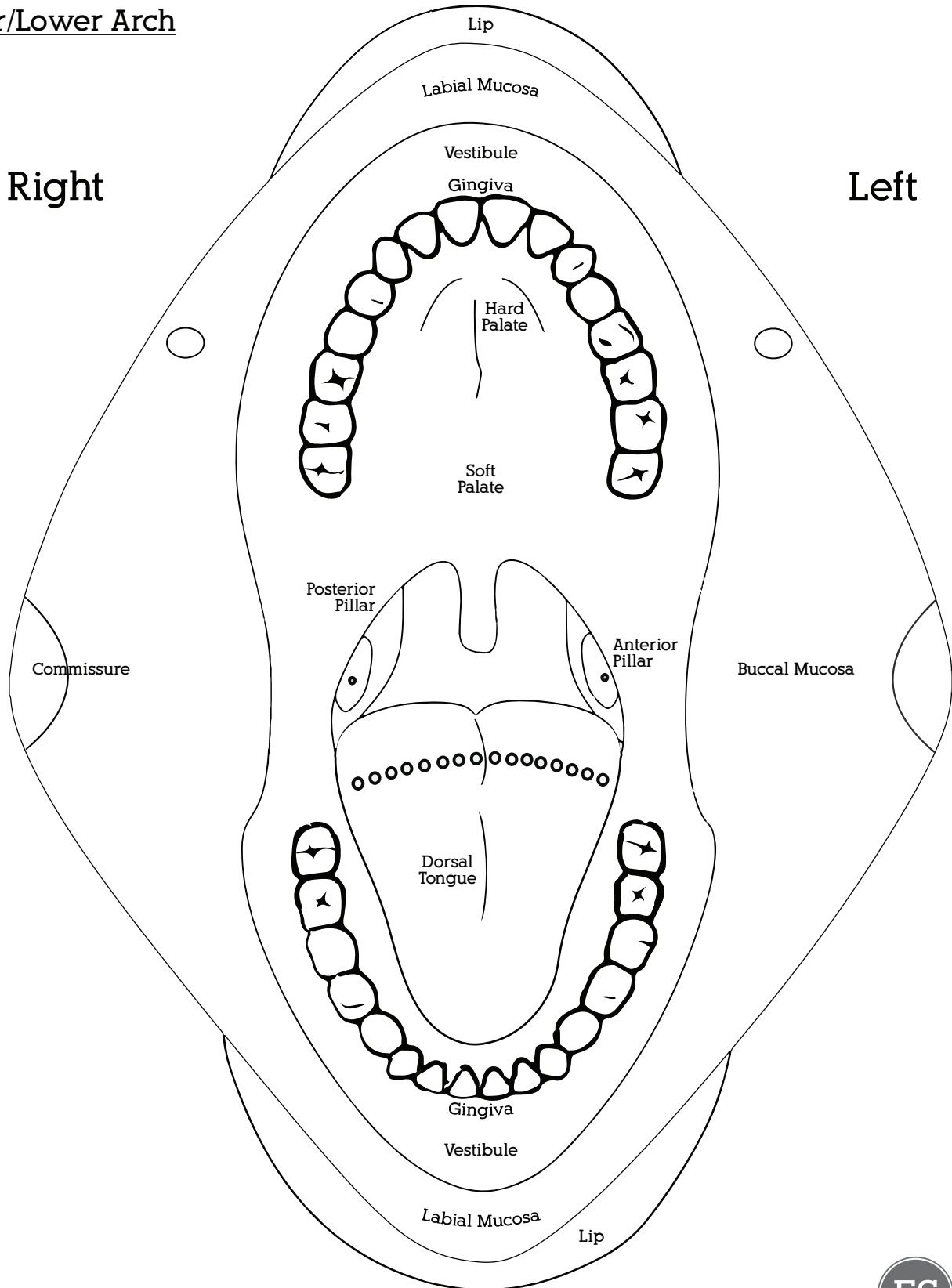


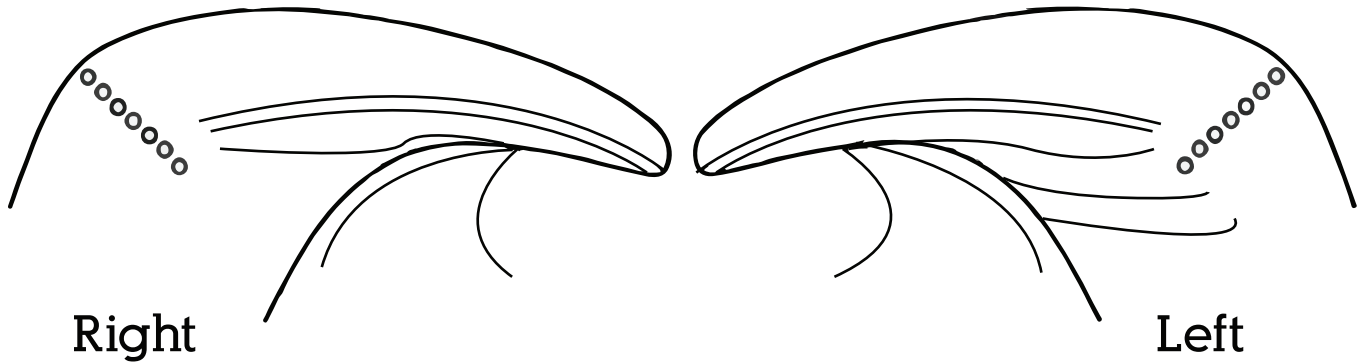
Patient Name:		Date:
Patient/Case Number:		Clinician:
Clinical Impression:		

## Upper/Lower Arch



Patient Name:		Date:
Patient/Case Number:		Clinician:
Clinical Impression:		

## Lateral Tongue



## Ventral Tongue

