



**REPAIR / INPUT FORM**

REPAIR    ESTIMATE  
 Visa  Master Card  Amex  Discover   
 Card #: \_\_\_\_\_  
 Exp. Date: \_\_\_\_\_ CVC #: \_\_\_\_\_  
 Card Holder's Signature

CUSTOMER \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_

CONTACT NAME \_\_\_\_\_ AUTHORIZED SIGNATURE \_\_\_\_\_

ITEM DESCRIPTION	SERIAL NUMBER	PROBLEM DESCRIPTION
1		
2		
3		
4		
5		
6		

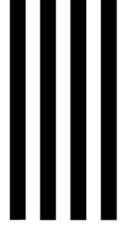


FROM: \_\_\_\_\_

**BUSINESS REPLY LABEL**  
FIRST-CLASS MAIL PERMIT NO. 100 NEW PARIS OH

POSTAGE WILL BE PAID BY THE ADDRESSEE

NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES



**HUGHES DIVERSIFIED DENTAL, LLC**  
PO BOX 9  
NEW PARIS OH 45347-9901

