Dental Prosthetic Services
Sleep Appliance Rx

Doctor:_____ **Patient:**_____

Phone: _____ Age: ❑ Youthful ❑ Middle-Age ❑ Mature

Address:_____ Gender: ❑ Female ❑ Male

City/State/ZIP:_____

Contact for case questions: _____

Contact email: _____ Email can be used for case questions? ❑ Yes ❑ No

Special delivery instructions: _____

_____

Deliver by 5:00pm on _____

Select Appliance Type

❑ EMA® Custom

❑ OASYS™
- ❑ Tongue lifting buttons

❑ Panthera D-SAD™ *(please complete Panthera Rx)*

❑ TAP® 3

❑ TAP® 3 AccuTherm

❑ dreamTAP™ *(Thermoblend)*

❑ dreamTAP™ DuraFit *(Thermoplastic)*

❑ dreamTAP™ AccuTherm

Trial Appliances (90 Day)

❑ EMA® First Step ❑ myTAP™

❑ SomnoDent™

Select SomnoDent body type

❑ Classic ❑ Fusion ❑ Herbst Advance

Select SomnoDent tray material

❑ Acrylic (ball clasps) ❑ Flex

Select SomnoDent options

❑ Anterior opening ❑ Bite ramp ❑ Elastics

❑ AM Reprogrammer *(included with appliances)*

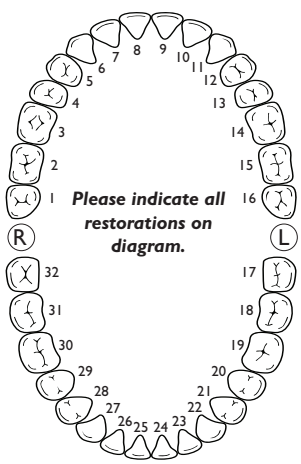
Materials Enclosed

❑ PVS impressions
- ❑ Upper ❑ Lower

❑ Models *(Grade 4 stone recommended)*
- ❑ Upper ❑ Lower

❑ **Intraoral scans sent**
System: _____

❑ Protrusive bite
right _____mm or left _____mm



Comments:

❑ **I would like a phone call regarding instructions**

Dental Prosthetic Services
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Cedar Rapids, Iowa 52402
800-332-3341 • Fax 319-393-8455
www.DPSdental.com

Please send my office:

❑ **Rx Fixed** ❑ **Rx Sleep**
❑ **Rx Removable** ❑ **Rx Implants**
❑ **Rx Ortho** ❑ **Boxes**
❑ **UPS/Mailing Labels**

Doctor Signature: _____

(Please select shade, age, gender, and delivery date)