

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
 - AccuTherm Thermoblend (TL)
- dreamTAP™
 - AccuTherm Thermoblend (TL)

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

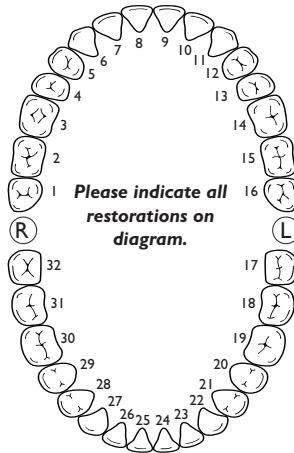
- AM Reprogrammer (included with appliances)

Trial Appliances (90 Day)

- EMA® First Step myTAP™

Materials Enclosed

- PVS impressions
 - Upper Lower
- Models (Grade 4 stone recommended)
 - Upper Lower
- Intraoral scans sent
System: _____
- Protrusive bite
 right _____mm or left _____mm



- I would like a phone call regarding instructions

Comments:

DENTAL PROSTHETIC SERVICES
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 www.DPSdental.com

Please send my office:

- Rx Fixed Rx Sleep
- Rx Removable Rx Implants
- Rx Ortho Boxes
- UPS Labels

Doctor Signature: _____
 (Please select shade, age, gender, and delivery date)