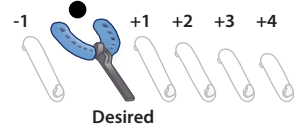
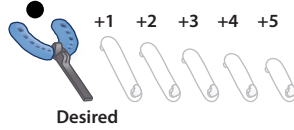
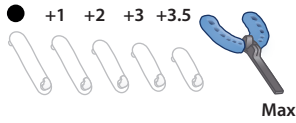




Dentist: \_\_\_\_\_ License #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Due Date: \_\_\_\_\_

**1 TREATMENT RANGE NEEDED ( ● Starting point )**

- Retrude 4mm with 0.5 mm step before patient's max.       Protrude 5mm.       Retrude 1mm and protrude 4mm.



**2 VERTICAL SPACING**

- Close or open to optimise the device  
 Keep it, call if major changes needed

**IS MANDIBULAR PROTRUSION STRAIGHT**

- Yes  
 No

**ELASTIC NOTCHES**

- No  
 Yes

**FRAGILE TEETH:**

Tooth #: \_\_\_\_\_

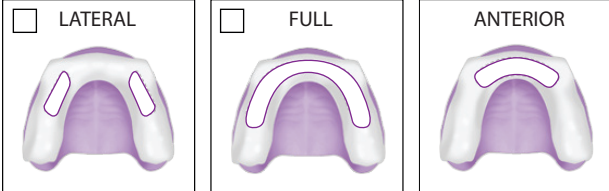
**CROWN AND / OR PONTIC:**

Tooth #: \_\_\_\_\_

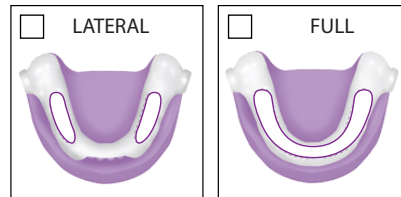
**USE OPTIMAL VALUES\***

- No     Yes    \* If YES checked, skip to section 5.

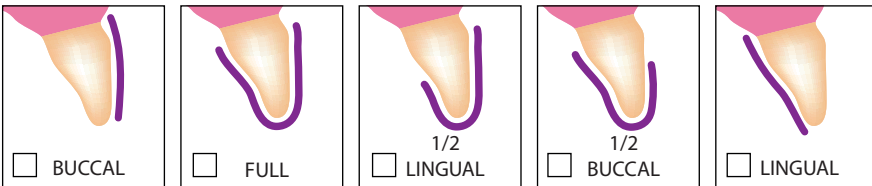
**3 UPPER PLATEAU**



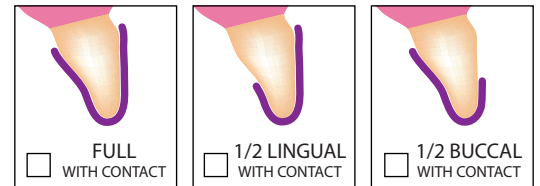
**LOWER PLATEAU**



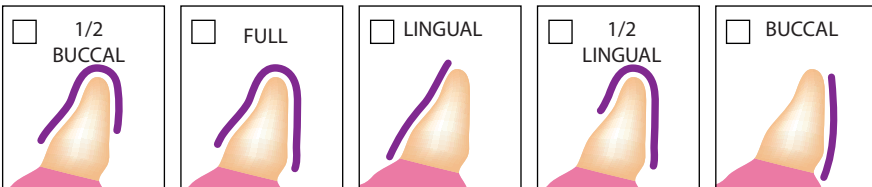
**4 UPPER BAND**



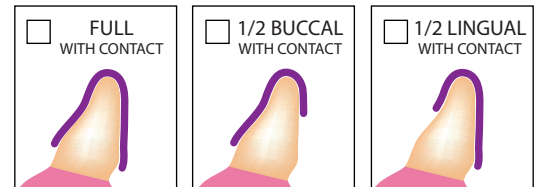
**ANTERIOR WITH CONTACT !**



**LOWER BAND**



**ANTERIOR WITH CONTACT !**



**5 EXTRA OPTIONS**

- Prefer upper splint distal wrap  
 Do not cover 3<sup>RD</sup> molar  
 Upper  
 Lower

**COMPOSITE BUTTON**

- Add if needed  
 Call me  
 Cancel case and ship back !



1900 51st Street NE  
 Cedar Rapids, Iowa 52402  
 Toll Free: 800-332-3341  
 Fax: 319-393-8455  
 www.DPSdental.com

**6 COMMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SIGNATURE**

- Do not call me if design changes are needed.

X \_\_\_\_\_