

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
☐ OrthoApnea NOA™ (please complete NOA Rx)
☐ Panthera Classic™ (please complete Classic Rx)
☐ Panthera X3™ (please complete X3 Rx)
☐ TAP® 3
☐ AccuTherm ☐ Thermoblend (TL)
☐ dreamTAP™
☐ AccuTherm ☐ Thermoblend (TL)

Trial Appliances (90 Day)

- ☐ EMA NOW™
☐ myTAP™

Materials Enclosed

- ☐ PVS impressions
☐ Upper ☐ Lower
☐ Models (Grade 4 stone recommended)
☐ Upper ☐ Lower

Intraoral scans sent

System: _____

- ☐ Protrusive bite
Protrusive Deviation
right _____mm or left _____mm

☐ I would like a phone call regarding instructions

SomnoDent™

Select SomnoDent body type

- ☐ Classic ☐ Fusion ☐ Herbst Advance

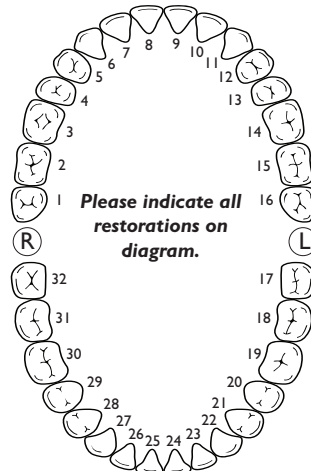
Select SomnoDent tray material

- ☐ Acrylic (ball clasps) ☐ Flex

Select SomnoDent options

- ☐ Anterior opening ☐ Bite ramp ☐ Elastics

- ☐ AM Reprogrammer (included with appliances)



Comments:

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 Labels

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