

DENTAL PROSTHETIC SERVICES

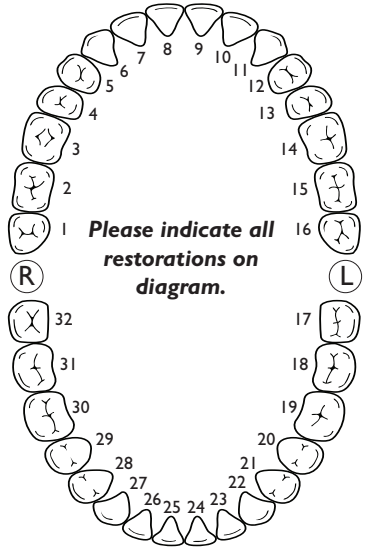
Sleep Appliance Rx



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® 3D
- EMA® Custom
- OASYS™
 - Tongue lifting buttons
- OrthoApnea NOA™ (please complete NOA Rx)
- Panthera Classic™ (please complete Classic Rx)
- Panthera X3™ (please complete X3 Rx)
- SomnoDent Herbst Advance
 - Acrylic Flex
 - Elastic hooks Anterior opening
- TAP® 3
 - AccuTherm Thermoblend (TL)
- dreamTAP™
 - AccuTherm Thermoblend (TL)



Trial Appliances (90 Day)

- myTAP™

I would like a phone call regarding instructions

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

Comments:

DENTAL PROSTHETIC SERVICES
 1900 51st Street NE
 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)