

PLEASE COMPLETE ENTIRE FORM.
COPIES NOT ACCEPTED, CALL SOMNOMED FOR NEW LAB SLIPS.
PRINT IN CAPITAL LETTERS

DENTIST INFORMATION:

Dentist Name: (first and last name) <input type="text" value="LAST"/> <input type="text" value="FIRST"/>	
Practice Name: <input type="text"/>	License #: <input type="text"/>
Address: <input type="text"/>	
City: <input type="text"/>	State: or Province <input type="text"/>
	Zip: or Postal <input type="text"/>
Phone: <input type="text"/> - <input type="text"/> - <input type="text"/>	Ext: <input type="text"/>
Email: <input type="text"/>	

DUE DATE NOT REQUIRED.
From date case is received at SomnoMed, please allow up to 14 business days for return delivery of completed appliance. When shipping please keep tracking number for your records.

PATIENT INFORMATION:

Patient Name: (first and last name) <input type="text" value="LAST"/> <input type="text" value="FIRST"/>	
Date of Birth: <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YY"/>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
AHI <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Method of diagnosis: <input type="checkbox"/> HST <input type="checkbox"/> PSG Facility: <input type="text"/>

PRODUCT INFORMATION:

<input type="checkbox"/> SomnoDent [®] Classic	<input type="checkbox"/> SomnoDent [®] Flex	QUANTITY: Please circle 1 2 Other (please specify) <input type="text"/>
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OPTIONAL FEATURES:

Anterior Opening Lingual-less (classic only) Flexiclose Endtulous (upper lower) Vertical Adjustment Height: Width:

ENCLOSED:

Upper and lower impressions (PVS or Silicone only)

Upper and lower models

Protrusive bite registration
Please note: protrusive bite registration should have 5.0mm opening at incisors.

FURTHER INSTRUCTIONS:

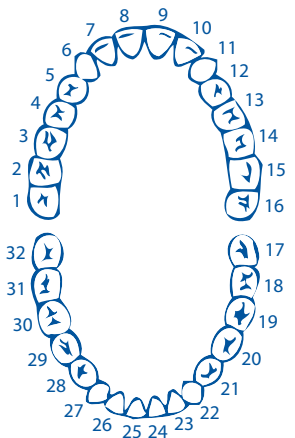
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DENTIST SIGNATURE: _____

DATE: _____

As a medical device company, we are mandated to validate any modifications to the 510(k) cleared device. This is a rigorous process which includes safety and effectiveness testing to ensure you receive a fully compliant device that exceeds your quality expectations. Any modifications performed after the device is released from SomnoMed null and voids your warranty and may result in the device not performing as intended. By signing above, you are stating the preferences listed above are what you wish to include in your device and you accept any responsibility for modification of the device after release from SomnoMed.

Second appliance discount valid for the same patient and must be requested on the original Rx. Additional appliance for the same patient not requested on original Rx, but at a later date, will be eligible for a discount. Discount cannot be combined with any other offer. Please contact SomnoMed for further details.

Please retain the bottom sheet and send all other copies with your order.

FOR INTERNAL USE ONLY.

Received Date: