SomnoDent® SLEEP APNEA DEVICE Repairs

☐ PLEASE CALL (This may delay delivery)

ATTN:

FOR INTERNAL USE ONLY

PAN#

USA: (888) 447-6673 Mon - Fri, 8am - 5pm CST • 6513 Windcrest Drive, Suite 100 Plano, Texas USA 75024
Canada: (800) 339-4452 Mon - Fri, 8am - 5pm EST • 221 Talbot Street West, Leamington, Ontario, Canada N8H1N8

www.somnomed.com

PLEASE COMPLETE ENTIRE FORM, SAVE FOR YOUR RECORDS, PRINT AND SEND IN WITH YOUR CASE. CONTACT CUSTOMER SERVICE FOR SHIPPING LABELS.

DENTIST INFORMATION:

Dealer #, if applicable:

Customer # :

Dentist Name: (last and first name) L A S T F I R S T

Practice Name:

License #:

Address:

City:

State: or Province

Zip: or Postal

Phone: - -

Ext:

Email:

Allow 6 business days from the date SomnnMed receives the device. Please include the completed Repair Rx, models or impressions, bite registration and device.

PATIENT RECORD

Patient Name:

Serial Number:

Original Insertion Date:

Reset

☐ Reset to current Current Titration: _____ ☐ Reset to bite (include bite)

Repair Fracture

☐ Maxillary Device ☐ Mandibular Device ☐ Other

☐ Wings ☐ Right ☐ Left

☐ Lug ☐ Right ☐ Left

Reline

☐ Reline Maxillary ☐ Reline Mandibular

Additional Options

☐ DentiTrac® Compliance Recorder (Not available in SomnoDent AIR)

☐ Add ☐ Remove | Share License Number _____

☐ Maxillary:	☐ Mandibular:
☐ ER hooks	☐ ER hooks
☐ 3 Pt. hooks	☐ 3 Pt. hooks
☐ Anterior opening	☐ Anterior opening
☐ DE/Bite ramp	☐ DE/Bite ramp
☐ Distal wrap	☐ Distal wrap

Reinforcement

☐ Add Reinforcement in Wings ☐ Add Reinforcement in Device

PLEASE INCLUDE THE FOLLOWING

☐ Upper and lower impressions or models
(PVS or Silicone only)
(Class IV Diestone Preferred)

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

☐ Disinfected & in plastic bag _____ Initials

PLEASE NOTE: A 3-5mm vertical clearance across the entire occlusal scheme (referencing the longest 2 opposing crowns) while the patient is in a comfortable protrusive position.

NOTES

FOR INTERNAL USE ONLY

RMA# PO#

SECTION TO BE COMPLETED BY DENTIST:

When submitting a repair case please only include the upper/lower, bite, and device. If accessories (retainer case, toolkit, SomGauge/George gauge) are submitted with the case they will be discarded and not replaced due to FDA Compliance regarding contamination.

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.

Please complete this form using Adobe Acrobat. Save a copy for your records, print a copy to send in with your order.

PLEASE DO NOT RETURN ACCESSORIES (STORAGE CASE, ADJUSTMENT TOOLS, BRUSHES, ETC.) WITH REPAIR CASES. SOMNOMED WILL NOT BE RESPONSIBLE FOR REPLACEMENT COST.