



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

www.somnomed.com

Canada: (800) 339-4452 Mon - Fri, 8am - 5pm EST • 221 Talbot Street West, Leamington, Ontario, Canada N8H1N8

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: | | Allow 6 business days from the date Somnomed receives the device. Please include the completed Repair Rx, models or impressions, bite registration and device. | | |
| City: | State: or Province | | | Zip: or Postal |
| Phone: - - | Ext: | | | Email: |

| | |
|--------------------------------------|---|
| PATIENT MEDICAL RECORD NUMBER | |
| Medical Record Number (MRN#): | *If patient name is entered, this will delay your case. Please list ONLY the patient chart number or medical record number to the left. |
| 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

| | |
|--|---|
| <input type="checkbox"/> Maxillary: <input type="checkbox"/> ER hooks <input type="checkbox"/> 3 Pt. hooks <input type="checkbox"/> Anterior opening <input type="checkbox"/> DE/Bite ramp <input type="checkbox"/> Distal wrap | <input type="checkbox"/> Mandibular: <input type="checkbox"/> ER hooks <input type="checkbox"/> 3 Pt. hooks <input type="checkbox"/> Anterior opening <input type="checkbox"/> DE/Bite ramp <input type="checkbox"/> 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

NOTES

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FOR INTERNAL USE ONLY
 RMA#

FOR INTERNAL USE ONLY
 PO#

SECTION TO BE COMPLETED BY DENTIST:

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.