

PLEASE CALL  
(This may delay delivery)

ATTN:



FOR INTERNAL USE ONLY

PAN#

Customer Service: (888) 447-6673 Mon - Fri, 8AM - 5PM CST | 7460 Warren Parkway, Suite 190 Frisco, Texas 75034 | 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:  
(first and last name)

L A S T

F I R S T

Practice Name:

License #:

Address:

Expected product delivery is approximately 14 business days from the date the order\* is physically received by SomnoMed.

\*Order includes completed lab slip, models or impressions, and bite registration.

City:

State:  
or Province

Zip:  
or Postal

Phone:

Ext:

Email:

PATIENT INFORMATION:

Patient Name:  
(last and first name)

L A S T

F I R S T

PHYSICIAN INFORMATION:

Referring Sleep Physician Name:  
(last and first name)

L A S T

F I R S T

DEVICE	QTY	REMAKE	
<input type="checkbox"/> SomnoDent® <i>Flex</i>		<input type="checkbox"/>	
<input type="checkbox"/> SomnoDent® <i>Classic</i>		<input type="checkbox"/>	(Ball clasp retained)
<input type="checkbox"/> SomnoDent® <i>Lingual-Less</i>		<input type="checkbox"/>	(Ball clasp retained)
<input type="checkbox"/> SomnoDent® <i>Herbst*</i> (E0486)		<input type="checkbox"/>	<input checked="" type="checkbox"/> Telescopic OR <input type="checkbox"/> Shim <input type="checkbox"/> SMH BFlex OR <input type="checkbox"/> Ball clasp retained
<input type="checkbox"/> SomnoDent® <i>G2</i>		<input type="checkbox"/>	<input type="checkbox"/> SMH BFlex <input type="checkbox"/> Ball clasp retained
<input type="checkbox"/> SomnoBrux®		<input type="checkbox"/>	<input type="checkbox"/> Maxillary <input type="checkbox"/> Michigan
			<input type="checkbox"/> Mandibular <input type="checkbox"/> Michigan <input type="checkbox"/> Tanner <input type="checkbox"/> Gelb

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

**MATRx™**

MATRx starting position \_\_\_\_\_ mm

ADDITIONAL OPTIONS

- Elastic (ER) hooks\*
- 3 Pt. hooks
- Anterior opening
- Wrap distal of last tooth
- Bite ramp discluding Element (height) \_\_\_\_\_
- Metal reinforcement in wings
- Metal reinforcement in occlusal surface

NOTES

.....

.....

.....

.....

.....

FOR INTERNAL USE ONLY

SO#

\* Same patient - 2nd appliance discount (30%) applies only when requested within six months of the original Rx. Discount cannot be combined with any other offer. Discount does not apply to the Herbst device. Please contact SomnoMed for further details.

\*ER hooks option no additional fee when ordering SomnoDent Herbst.

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.

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

FOR INTERNAL USE ONLY

PO#