SomnoDent® SLEEP APNEA DEVICE Repairs

☐ **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) LAST FIRST

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 INFORMATION:

Patient Name: (first and last name) LAST FIRST

Serial # : **Original Insertion Date :**

Reset

☐ Reset to current ☐ 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

☐ Add ☐ Remove

☐ **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

SECTION TO BE COMPLETED BY DENTIST:

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

NOTES

FOR INTERNAL USE ONLY

RMA#

FOR INTERNAL USE ONLY

PO#

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.

 SD REPAIR FORM 903015 Rev. A