



PLEASE PHONE ME CONCERNING THIS CASE

DOCTOR _____ DATE SENT _____

E-MAIL ADDRESS _____ DATE WANTED _____

ADDRESS _____

CITY _____ PROVINCE _____

POSTAL CODE _____ TELEPHONE _____

PATIENT'S NAME _____ PATIENT'S AGE _____
(please print)

PLEASE SEND SUPPLIES:

- RX SHEETS
- RX LABELS
- SHIPPING BAGS
- EXTRA PROGRESS REPORTS
- SHIPPING BOXES
- EXTRA APPLIANCE KEYS



D-SADTM APPLIANCE

DIGITAL - SLEEP APNEA DEVICE

PROTRUSIVE BITE

- BITE REPRESENTS MAXIMUM PROTRUSION
- BITE REPRESENTS STARTING POINT

VERTICAL DIMENSION

- CLOSE AS NEEDED
- AS PER BITE

LATERAL DEVIATION

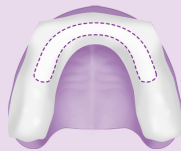
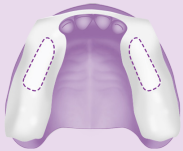
- NONE
- YES

BRUXISM

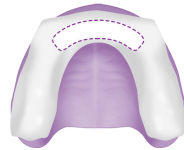
- NONE - LIGHT
- MODERATE - SEVERE

PLATEAU (CHECK ONE UPPER & ONE LOWER)

- STANDARD
- FULL



- ANTERIOR



COMPLETE IF ANTERIOR IS CHECKED

WIDTH CENTRAL ONLY

-

LATERAL TO LATERAL

-

CANINE TO CANINE

-

- STANDARD



- FULL



- ANTERIOR

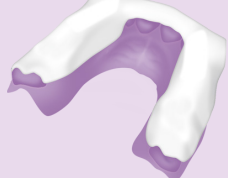


BAND (CHECK ONE UPPER & ONE LOWER)

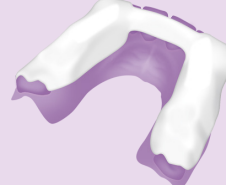
- SIMPLE BUCCAL (recommended)



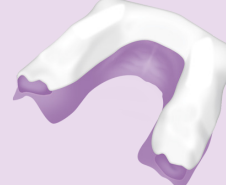
- 3/4



- SIMPLE LINGUAL



- FULL



- 3/4 (recommended)



- SIMPLE LINGUAL



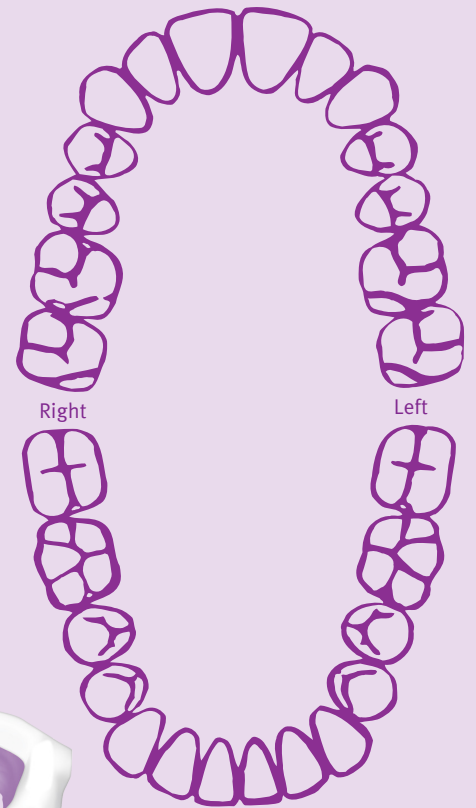
- SIMPLE BUCCAL



- FULL



APPLIANCE DESIGN



SPECIAL INSTRUCTIONS: _____

DOCTOR'S SIGNATURE: _____