SML
SPACE MAINTAINERS LABORATORIES

SomnoMed
Dental • Sleep • Medical

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Calgary 403-228-5120 | Fax 403-228-8614
Toll Free 1-800-661-1169 | Toll Free Fax 1-888-812-3786

DENTIST INFORMATION:

Dentist Name: (first and last name) LAST FIRST

Practice Name: License #:

Address:

City: Prov: Postal Code:

Phone: - - Ext: Email:

PATIENT INFORMATION:

Patient Name: (first and last name) LAST FIRST

Date of Birth: MM DD YY Gender: ❑ Male ❑ Female AHI ❑ Mild ❑ Moderate ❑ Severe

Method of diagnosis: ❑ HST ❑ PSG ❑ Facility: _____

❑ SomnoDent® Classic | ❑ SomnoDent® Flex | ❑ SomnoDent® G2 | ❑ SomnoDent® LVI Lingual-less

QUANTITY:

Please circle 1 2 Other (please specify) _____

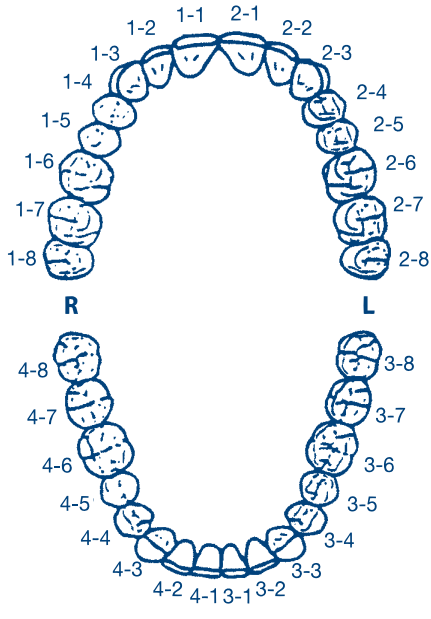
OPTIONAL FEATURES:

❑ Anterior Opening ❑ Lingual-Less (classic only) ❑ Elastic Retention (Hooks for Elastics) ❑ Edentulous (❑ upper ❑ lower)

❑ Vertical Adjustment Height:_____ Width:_____

ENCLOSED:

- ❑ Upper and lower impressions (PVS or Silicon only)
- ❑ Upper and lower models
- ❑ Protrusive bite registration
  Please note: Protrusive bite registration should have 5.0mm opening at incisors.



FURTHER INSTRUCTIONS:

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DENTIST SIGNATURE:

DATE:

PLEASE COMPLETE ENTIRE FORM.
COPIES NOT ACCEPTED.
PLEASE CALL AURUM/SPACE MAINTAINERS FOR NEW LAB SLIPS. PRINT IN CAPITAL LETTERS.

FOR INTERNAL USE ONLY
Received Date:

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