:) CUSTOM SMILES Z Z Z Z

DOCTOR'S NAME _____ ACCOUNT# _____

ADDRESS _____ DATE _____

PATIENT NAME _____ DELIVERY DATE _____

Oral Sleep Apnea Appliances

Appliance Type: ☐ EMA ☐ Dorsal ☐ Herbst

Please include the following with Case:

☐ Upper and lower impressions
(PVS or Silicone only)

☐ Protrusive bite registration
(Protrusive bite registration 5.0mm opening at incisors)

MATRx starting position: _____mm

Rx

Made in the USA

Signature _____ License #_____

2530 Lane Street
Kannapolis, NC 28083

:) CUSTOM SMILES
dental laboratory

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