

Doctor _____ Phone _____

Address _____

Patient Name _____ request technical call-back _____ clinical _____ laboratory

DELIVERY APPOINTMENT DATE _____ *****(mandatory)*** TIME** _____

Typical *time-in-lab* is 8 working days. Call to expedite service as needed

TALON® Retained Inter-occlusal Appliances - Splints / Night Guards / TMD Appliances
_____ MAXILLARY _____ MANDIBULAR

TAP® Appliance for the Management of SLEEP-DISORDERED BREATHING

Retention TL _____ (*Tri-laminate / formed to cast*) **Thermacryl** _____ (*Directly formed to the teeth at delivery appt*)

Please include the **TAP Technique DVD** _____ (*Essential for any practitioner*)

Total Protrusive Range of Motion _____ mm George gauge measurements _____ mm + / _____ mm -

Bite is: _____ 50% of Protrusive ROM _____ 60% _____ % Vertical Dimension (inter-incisal distance) _____ mm / standard _____

OTHER _____ **ATHLETIC MOUTH GUARD** _____ **ORTHO FINISHER** _____ **CUSTOM** _____

Instructions _____

Dr's signature _____ **License number** _____

***Rush service**—minimum two working days in lab \$30.00 (shipping excluded) *Die stone is recommended * Clinical Consultation available