FOR INTERNAL USE ONLY	FOR INTERNAL USE ONLY
SO#	PAN#

SomnoMed® SleepWorks Medical Inc.

FULL LINE PRODUCT ORDER FORM

☐ PLEASE CALL *(may delay delivery)*

DUE BY ___/___/_____

PLEASE COMPLETE FORM. SAVE FOR YOUR RECORDS, PRINT & SEND WITH CASE. CONTACT CUSTOMER SERVICE.

Canada: (800) 339-4452 Mon - Fri, 8am - 5pm EST • 221 Talbot Street West, Leamington, Ontario, Canada N8H1N8 **www.somnomed.com**

DENTIST INFORMATION

Customer # :

Dentist Name: (last and first name) L A S T	F I R S T
Practice Name:	License #:
Address:	
City:	Province:
Phone: - -	Ext: / Email:

PATIENT INFORMATION

Patient Name: (last and first name) L A S T	F I R S T	Email:

Is this the patient's first oral device? ☐ Yes ☐ No If no, please list previous devices:

PHYSICIAN INFORMATION

Referring Physician Name: (last and first name) L A S T	F I R S T	Email:

SOMNODENT™ ORAL DEVICE CHOICE	QUANTITY
☐ Fusion® (B Flex retention)	
☐ SUAD Ultra™	

NOTES

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SECTION TO BE COMPLETED BY DENTIST

DENTIST SIGNATURE: (per state dental board requirements) **DATE:**

Caution: Federal law restricts this device to sale by or on the order of a (licensed healthcare practitioner).
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 recieve 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.

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