

PLEASE PRINT:

Doctor: _____ Lic#: _____

Address: _____

Phone: _____

Email: _____

Patient Name: _____

Date Sent: _____ Case Due Date: _____

I. SELECT YOUR NTI

NTI-tss Plus™ – Lab Recommended Design

OR

Specify the NTI Design:

NTI-tss Plus (Night-time Use, Most Popular Design)

NTI-tss Plus Soft (must be extended 2nd bi to 2nd bi)

NTI-tss Plus Daytime (Anterior Point Stop)

NTI-tss Plus Extended Coverage (From _____ to _____)

NTI-tss Plus Migraine Therapy Set (NTI-tss Plus & NTI-tss Plus Daytime)

NTI-tss Plus Universal Therapy Set (NTI-tss Plus & Opposing Slidebar)

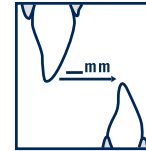
Choose the Arch:

Upper Lower Lab Choice

II. DOCUMENT MEASUREMENTS & COMMENTS

Measurements:

Maximum Protrusive Measurement _____mm



Enclose full arch PVS impressions and centric bite.

Comments:

Dr.'s Signature: _____

Date: _____