ENDSNOR™ APPLIANCE

The dentist-prescribed solution to snoring.

Dr. ____________________

Address ____________________

City __________ State ______ Zip ______ Ph. 1-( ) ______

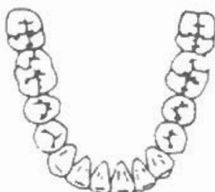
Patient *(Print)* ____________________

Date of Impression ____________________

FINISH TIME

Please check below on what you have enclosed.

- ☐ EndSnor
- ☐ Upper model
- ☐ Lower model
- ☐ Wax bite
- ☐ Open 5 mm
- ☐ End to End



Instructions:

Dr. Signature ____________________

Lic. # ____________________ Date ____________________

Dockstader

YOUR FULL SERVICE DENTAL LAB

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559 / 439-5160 TOLL FREE 1-800 / 433-7168 FAX 559 / 439-8147
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