Cosmetic Dentistry
ASSOCIATES

Peter Auster, D.M.D.

Frances Tang, D.D.S.

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Cosmetic Dentistry Associates, PLLC

DELIVERY FORM

DELIVERED TO:	DELIVERED BY:
Patient's Name: Date of Birth:	Clinician's Name: ________________________
Patient's Street Address: City, State, Zip:	COSMETIC DENTISTRY ASSOCIATES 1540 Route 202, Suite 14 Pomona, NY 10970
Item Delivered: Oral Sleep Appliance-E0486	**Quantity Delivered:** One (1)

Description of Item/Type of Appliance:

- ☐ **EMA**
- ☐ **SomnoMed**
- ☐ **TAP III Elite**
- ☐ **UCLA Modified Herbst Model # 63250**
- ☐ **Dorsal**
- ☐ **Other:** ________________

Patient's Signature: **Date:**

Clinician's Signature: **Date:**

☐ **Appliance warranty given to patient**

Clinician's initials: **Date:**

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