PRESCRIPTION & ORDERING

Rx for Tic Active Guard

TAG
TOURETTE SYNDROME RESEARCH

Please construct one TAG appliance to the vertical dimension enclosed.

LAB USE ONLY

Pan No. _____ Case No. _____ Received _____

PATIENT INFORMATION

Patient Name _____ Sex M ◯ ◯ F Age ____

Address _____

City/State _____ Zip _____ Country _____

Phone _____ Email _____

DOCTOR INFORMATION

Doctor Name _____

Address _____

_____

City/State _____ Zip _____ Country _____

Phone _____ Email _____

SHIPPING COST

Rush shipping charges apply. Please note that we will ship FedEx Ground if no selection is made. Free FedEx Ground services ONLY available in the Continental U.S.

◯ FREE FedEx Ground ◯ FedEx 2nd Day Air ◯ FedEx Priority Overnight

ADDITIONAL NOTES

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Please send: ◯ Labels ◯ Shipping Boxes Other _____

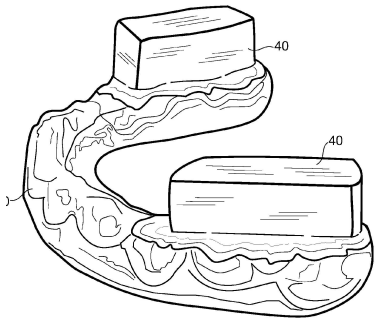
MATERIALS USED: APPLIANCE: POLYETHYLENETEREPHLATATE, ETHYLVINYLACETATE, RADIOPAQUE ACRYLIC

Clinical Requirements:

U/L Polyvinylsiloxine (PVS) impressions which includes an accurate representation of the occlusal surfaces and provides extension into the buccal vestibule with a clear impression of the supra and infra bulge of the buccal and lingual surfaces of the mandibular posterior teeth.

A bite registration in Maximum Inter-Cuspation (MIC) or Centric Occlusion (CO)

A bite registration to a reproducible vertical dimension that reduces the tics to a maximum amount. Tongue depressors are commonly used to maintain and reproduce the new vertical dimension. The bite registration will include a posterior and anterior imprint of the teeth to allow the lab to articulate the models using a triangulation technique.



I (prescribing doctor) understand and acknowledge that I am not making any medical claims that the TAG Appliance will reduce motor and vocal tics commonly associated with Tourette Syndrome (TS) or Chronic Tic Disorder. (CTD) I am prescribing a modified occlusal guard with a posterior platform to establish a vertical dimension that may or may not reduce motor and vocal tics. This has been explained to the patient and/or the patients legal guardian or parent(s). If the patient is a minor, the patient has provided assent and agrees to wear the appliance for the possibility that it may reduce motor and vocal tics commonly associated with TS and CTD.

FORM MUST BE SIGNED FOR ORDER TO BE PROCESSED!

LICENSE NO. _____

SIGNATURE _____ **DATE** _____

PLEASE RETAIN A DUPLICATE COPY OF THIS ORDER FORM.

SEND TO

Oral Care Perfected, Inc
3000 Ravenswood Road, Suite 1A
Fort Lauderdale, FL 33312
Toll Free 844-949-2789
Email: orders@smileperfected.com

REV 7-2019