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We do not perform in-office sedation.
We may recommend completing treatment in a hospital setting.

Please complete the following information: Date of referral _____

Patient's name _____ M/F DOB_____

Parent's name _____

Address_____ City_____

Telephone Home _____Work/Cell_____

Referred by _____

Is the patient in pain? Yes No

Please check all that apply:
☐ Young age ☐ Extensive work needed ☐ Patient uncooperative
☐ Significant Medical History_____
☐ Medications_____

Treatment completed: ☐ X-rays (PLEASE FORWARD)* ☐ Prophy*
☐ Restorative work*_____
*PLEASE INCLUDE DATE COMPLETED

Areas of concern:_____
_____
_____

Would like this patient to return to our office for routine care: ☐ Yes ☐ No

Appointment: Date _____ Time_____