Sleep Dentistry OF SPOKANE

Comprehensive Dentistry YOUR Way...Awake, Asleep or In-between

Patient Referral Form

Appointment Date

Time

:

HH MM

If you are unable to keep this appointment, 24 hours is required for cancelation. Please bring insurance cards & identification to your appointment.

Provide One

- ☐ Insurance
- ☐ Cash/Check
- ☐ Credit Card
- ☐ Care Credit

Introducing*

First Last

Date of Birth*

Parent/Guardian

First Last

Phone*

Referred By

First Last

Date

Return of Patient*

- ☐ Return of patient not required
- ☐ As a patient of record, return to my office

Radiograph

- ☐ Sent with patient
- ☐ Mailed
- ☐ Emailed to Xrays.OANDS@gmail.com

Sedation Reason

- ☐ Extensive Dental Disease
- ☐ Dental Phobia
- ☐ Age/Behaviour Management
- ☐ Developmental Disability
- ☐ Other

Approach

- ☐ General Anesthesia
- ☐ Oral Sedation
- ☐ Local Anesthetic

☐ LEFT ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐ J ☐ RIGHT

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16

☐ 32 ☐ 31 ☐ 30 ☐ 29 ☐ 28 ☐ 27 ☐ 26 ☐ 25 ☐ 24 ☐ 23 ☐ 22 ☐ 21 ☐ 20 ☐ 19 ☐ 18 ☐ 17

☐ T ☐ S ☐ R ☐ Q ☐ P ☐ O ☐ N ☐ M ☐ L ☐ K

Referred For

- ☐ Emergency Evaluation Pain/Swelling
- ☐ Implant/Pre-Protectic Evaluation
- ☐ Frenectomy/Apicoectomy
- ☐ Restorative
- ☐ Endontic Therapy
- ☐ Extractions

Please fill out this form, and then print and fax to Sleep Dentistry of Spokane at (509) 534-1015