Sedation and Implant Dentistry Las Vegas

1825 E Flamingo Road, Las Vegas, NV 89119
(702) 763-3649
DentistLasVegas.com

REFERRAL FORM

Referring Doctor:____ Date:____________________

Phone: ____________________________ Email: ____

Patient Name: ____

Phone Number:________________________ Date Of Birth:______________________

Teeth:____

UR	1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	UL
LR	32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	LL

Notes____
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CONSULTATION FOR

Sleep Apnea________ Implants_______ Tmj________ Endodontic________

Laser Perio ________ iCAT________ Other____________________________________

IV SEDATION FOR

Dental fears____ Unable to anesthetize____ Gag reflex ____ Limited opening ____

All on 4's _____ Implants____ Full mouth treatment_____ Other____________________

APPOINTMENT DATE:__________________TIME:___________