TOWN CENTER DENTISTRY

SEDATION & IMPLANT DENTISTRY

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Date:_____ Referring Doctor:_____

Ref Phone Number:_____ 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

IV Sedation for:

Dental fears____ Unable to anesthetize____ Gag reflex ____

Limited opening ____All on 4's _____ Implants_____

Full mouth treatment_____ Other_____

CONSULTATION FOR:

SLEEP APNEA_____ IMPLANTS_____ ALL ON 4's_____

TMJ_____LASER PERIO TREATMENT_____

I-CAT _____ OTHER_____

Notes:_____