Sleepy Owl Dentistry

Board Certified Pediatric Dentists

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Date ____ / ____ / ____

Patient name _____ DOB ____ / ____ / ____

Parent/Legal guardian name _____

Parent/Legal guardian phone (____) ____ - ____

Referred by _____

Referring Dr.'s phone (____) ____ - ____

X-Rays taken? ❑ Yes ❑ No

Reason for referral **** Please send clinical documentation.***

- ❑ Age (2+ years old)
- ❑ Behavior*
- ❑ Dental anxiety*
- ❑ Failed oral conscious sedation*
- ❑ Failed nitrous oxide*
- ❑ Failed local anesthesia*
- ❑ Extensive dental needs (two or more quadrants)
- ❑ Strong gag reflex
- ❑ Medical history
- ❑ Other _____

Referred treatment plan/Comments _____