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ITANI DENTAL

HOUSE CALL DENTAL SEDATION

Introducing: _____

DOB: _____ Guardian: _____

Phone: _____ Email: _____

Reason for referral: ☐ Hospital General Anesthesia ☐ Intravenous Conscious Sedation ☐ House Call Services
☐ Gag Reflex ☐ Dental Anxiety ☐ Special Care ☐ Difficulty getting numb

X-rays: ☐ To be taken ☐ Could not be taken ☐ Will be emailed

Mobility: ☐ Ambulatory ☐ Needs assistance ☐ Wheelchair ☐ Non ambulatory

Instructions or remarks: _____

_____

Referred by: _____ Phone: _____ Email: _____

Address: _____ Signature: _____ Date: _____