100 N. Mullan Rd., Suite 204
Spokane Valley, WA 99206
Phone: 509-900-6300
Fax: 509-204-8110

Email X-rays to: x-rays@apexsleepdentistry.com

Introducing: ______________________________ **DOB:**__________ **Date:** __________
Parent/Guardian:______________________________ **Phone**:______________________
Address: ____

Preferred language: ☐ English ☐ Spanish ☐ Russian ☐ Other ___________

Referred for: ☐ Sedation

Sedation Reason:
☐ Extensive dental disease
☐ Developmental disability
☐ Other ______________________
☐ Behavioral management issues
☐ Dental Phobia

Needed Treatment:
☐ Extractions ________
☐ Perio __________
☐ Endo __________
☐ Restorative ________
☐ Emergency Eval Pain / Swelling________
☐ Implants __________
☐ Other ____________________

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

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Insurance / Financial responsibility: ☐ Apple Health ☐ Self Pay ☐ Insurance ☐ ID Smiles

Referred by: ______________________________**Phone:** ________________
☐ Patient will return to my office ☐ Return of patient not requested

Radiograph: ☐ Sent with patient ☐ Mailed ☐ Emailed to: **X-rays@apexsleepdentistry.com**