APEX
SLEEP DENTISTRY
Ambulatory & Office-Based General Anesthesia/Sedation

DENTAL SEDATION REFERRAL FORM

Please complete all sections of this form and retain a copy for your records.

RETURN FOR ROUTINE CARE? ☐ YES ☐ NO

PRIORITY ☐ URGENT ☐ ROUTINE

Patient Name: _____

Birthdate: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Cell Phone: _____ **Home Phone:** _____

Address: _____

Parent / Guardian: _____

Primary Ins.: _____ **ID#:** _____

Secondary Ins.: _____ **ID#:** _____

Practice Name: _____

Office Contact / Coordinator: _____

Direct Phone: _____ **Fax:** _____

Office Email: _____

Date: _____

JUSTIFICATION FOR REFERRAL - Check all that apply

- ☐ Anesthetic allergy
- ☐ Anxiety / fear
- ☐ Behavior / lack of cooperation
- ☐ Can't get numb
- ☐ Pronounced gag reflex
- ☐ Developmental disability / delay
- ☐ Needle phobia
- ☐ Prolonged or unpleasant treatment
- ☐ Other - please list: _____

TREATMENT AREAS

TEETH TO TREAT

Circle or check the tooth numbers.

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

PROCEDURES

- ☐ Comprehensive exam and care
- ☐ Restorative / fillings
- ☐ Endodontics / pulpal
- ☐ Implants / surgery
- ☐ Extractions / oral surgery
- ☐ Crowns / fixed prosthetics
- ☐ Periodontal / hygiene
- ☐ Other: _____

PATIENT INSTRUCTIONS: Please bring Photo ID & Dental Insurance Card to your appointment. Intake forms are completed securely online prior to visit.

☐ **Preferred Location: SPOKANE VALLEY OFFICE**
100 N. Mullan Road, Suite 204
Spokane Valley, WA 99206
Phone: (509) 900-6300 | Email: office@apexsleepdentistry.com

☐ **Preferred Location: MOSES LAKE OFFICE**
825 Sharon Ave E
Moses Lake, WA 98837
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