



THE DENTAL

ANESTHESIA CENTER

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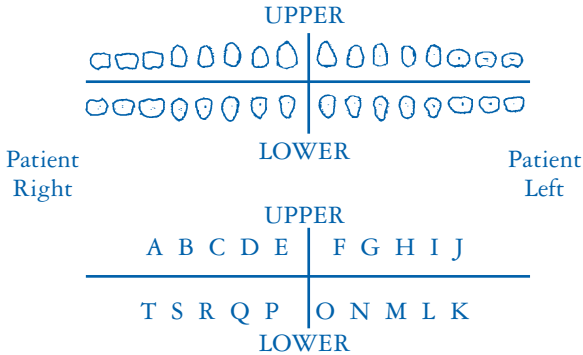
Date: _____

Dr. _____
(Referring Dentist)

would like to refer: _____

to The Dental Anesthesia Center for consultation regarding General Anesthesia/Sedation and the following

- _____ Complete Comprehensive Examination
- _____ Implant
- _____ General Restorative
- _____ Reconstruction Rehabilitative Dentistry
- _____ Endodontic
- _____ Other (see below)



Additional Comments _____

Advise your patient to call for an initial consultation.

Please email radiographs and treatment requested to dac950@aol.com.