THE DENTAL
ANESTHESIA CENTER
MICHAEL J. HOFFMANN, DDS
MARIS E. BEHL, DDS
SEAN M. THOMS, DMD, MS

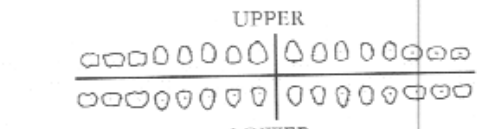
Date:

Dr. _____
(Referring Dentist)

would like to refer: _____

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

_____Pediatric Patient (unable to cooperate)
_____Special Needs
_____Severe Gag Reflex
_____Complications with Local Anesthesia
_____Medically Complex
_____Severe Dental Anxiety
_____Extensive Treatment Plan



Patient Right

Patient Left

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

❑ Digital radiographs of diagnostic quality are available.

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

Additional Comments _____

_____

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Advise your patient or their guardian to call for a pre-operative consultation.

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