SAN ANTONIO DENTAL TEAM

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8706 Fredericksburg Road, Suite 104
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New Patient Referral

Referring Provider

Office Name: _____ Telephone: _____

Doctor Name: _____ Signature: _____

Patient Information

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

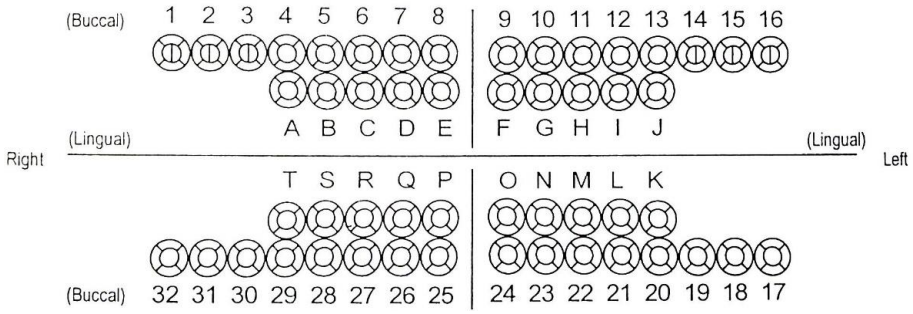
Name: _____ Date of Birth: _____

Telephone #1: _____ Telephone #2: _____

Treatment Requirements

☐ 1–2 Teeth ☐ 3–4 Teeth ☐ 5–8 Teeth ☐ 9+ ☐ Other / Details: _____

Optional:



Reason for Referral

☐ Failed conscious sedation (e.g. nitrous oxide and/or oral sedatives)

☐ Unable to cooperate due to lack of physical or emotional maturity

☐ Required procedure is longer than patient can tolerate without sedation

☐ Condition requiring medical supervision, or special healthcare needs

☐ Other / Comments: _____

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