

Date: ___/___/_____

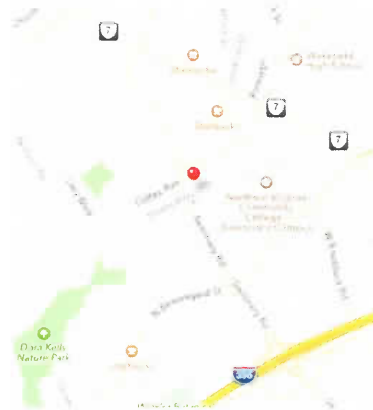
Patient's Name: _____

Referred by: _____

- Radiographs enclosed Y or N
- Treatment plan enclosed Y or N
- Contact prior to visit:
Phone # _____

Reason for Referral: (check all that apply)

- General Anesthesia consult
- Pediatric
- Special needs
- Local Anesthetic concern
- Complex Medical History
- Dental phobia
- Implant / Surgery
- Other _____



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CENTER FOR DENTAL ANESTHESIA

Our Office is Your Office

Treat your phobic, special needs, or complex cases in the safety of our state of the art dental anesthesia facility.

Contact us at (703) 379-6400 for details

Center for Dental Anesthesia

We are here for YOU and YOUR PATIENTS!

Do you have phobic patients who have developed trust in your expertise and don't want to see anyone else? No matter how much they trust you the thought of an injection or the sound of a dental drill sends them into a panic. How about that full mouth reconstruction case you've been talking about with that pt. who is too busy to commit to several appointments. Maybe you have a special needs pt. who because of their disability, is extremely difficult to treat. Don't send them to someone else! See them YOURSELF in one of our fully equipped dental suites.

Ask us about our hourly Facility fee!

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