GINA L. SALATINO
D.M.D.

SEDATION DENTISTRY REFERRAL

Referred by: Dr. _____ **Office Phone #:_____**

Patient Information:

Name: _____ Date of Birth: _____

Email Address: _____ Phone Number: _____

Where Would You Like the Dental Treatment to Be Conducted?

- ☐ Dr. Salatino travels to your office to provide sedation while you complete dental treatment.
- ☐ The patient will be seen at Dr. Salatino's office for sedation and dental treatment.

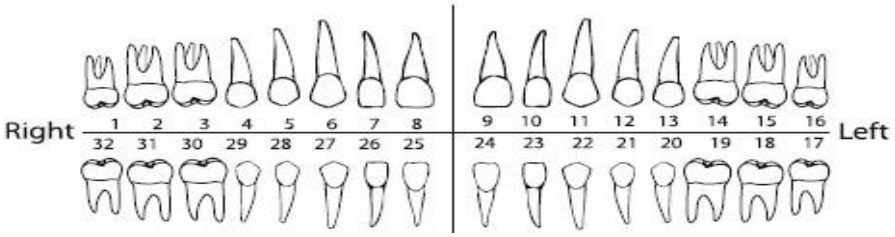
Dental Exam:

- ☐ Treatment plan emailed
- ☐ Comprehensive examination needed

Radiographs:

- ☐ Radiographs will be emailed
- ☐ Please take

Proposed Dental Treatment:



Restorative Needs:

- ☐ Fillings
- ☐ Crown(s)
- ☐ Bridge (s)

Hygiene:

- ☐ Scaling & Root Planing
- ☐ Prophylaxis

Surgical Needs:

- ☐ Third Molar Extraction(s)
- ☐ Extraction(s)
- ☐ Implant(s)

What Are the Patient's Dental Phobias That Require Sedation?

- ☐ Needle Phobia
  - Can the patient tolerate an IV placement? YES / NO
- ☐ Anxiety
- ☐ Fear of Dental Surgery
- ☐ Dental Sounds
- ☐ Dental Phobia
- ☐ Severe Gag Reflex

Remarks:_____

_____

Please email the patient's health history with referral. Thank you. Info@RockstarFamilyDental.com