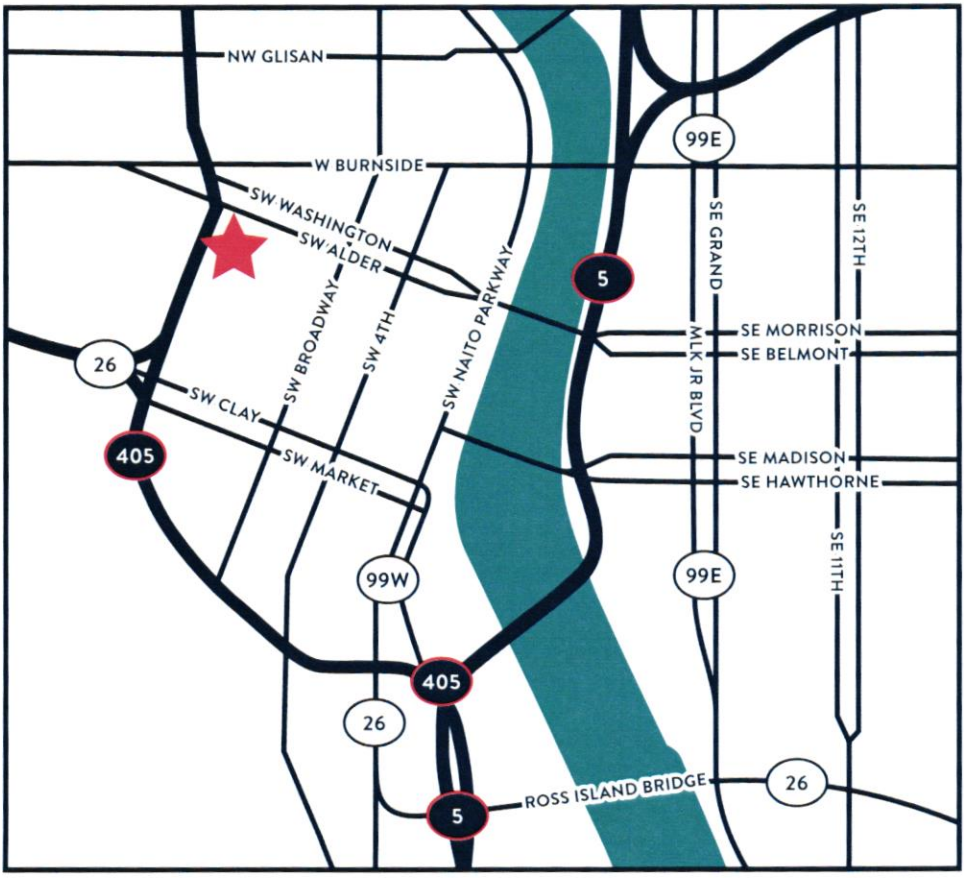
DOWNTOWN
DENTAL
ASSOCIATES

JAKE D. BECKER, DMD
1221 SW Yamhill, Suite 310
Portland, Oregon 97205
503-227-0958
ddaportland.com

COMMENTS



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REFERRAL FOR SEDATION / ANESTHESIA

REFERRING DENTIST: _____

Phone: _____ Date: _____

Patient's Name: _____

Phone: Daytime: _____ Evening: _____

- ☐ Patient will call
- ☐ We should call patient
- ☐ Appointment made _____

REQUESTED TREATMENT:

- ☐ Complete Dental Examination and Treatment
- ☐ Specific Dental Treatment _____

_____

_____

RADIOGRAPHS:

- ☐ PAX/BMX: (date) _____
- ☐ Pano: (date) _____
- ☐ Please take x-rays: _____
- ☐ Being sent
- ☐ With patient
- ☐ Sending by email to: info@ddaportland.com

PATIENT INFORMATION

- ☐ Return patient for my regular care
- ☐ Maintain patient's care in your office
- ☐ Dental Situational Phobia
- ☐ Patient management concern: _____

_____

- ☐ Incomplete anesthesia: (area) _____
- ☐ Mental or physical handicapped: _____

_____

- ☐ Specific circumstance of referral: _____

_____

- ☐ Specific procedure for referral: _____

_____