Paul R. Griffith, D.D.S.
Amy R. Griffith, D.D.S.

Sedation Dentistry

Patient Referral Form

Date:_____ Patient:_____ Age:_____

Referred by:_____ Office Phone:_____

Office Email:_____

Reason for Referral:

□ Full Mouth Evaluation & Treatment

□ Treatment of Specific Teeth:_____

Sedation: □ Nitrous □ Conscious Sedation □ General Anesthesia

□ Other: _____

_____

_____

_____

_____

This patient will go back to the referring doctor after treatment is completed:

□ Yes □ No □ Patient to Decide

Date of Current Xrays:

□ BWX:_____ □ PAs:_____ □ Pano:_____

□ Sent to admin@drgriffith.com

1565 Hollenbeck Ave #116, Sunnyvale, CA 94087 | 408.736.6856