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DENTAL SEDATION SERVICES

TO BE COMPLETED BY THE DENTAL OFFICE

SEDATION REQUEST FORM

Current Date:	**Dental Office Name:**
Treating Dentist:	**Office Contact Name & Phone Number:**

PATIENT INFORMATION:

Patient Name:	**DOB:**	**Email:**
Primary Phone Number:	**Secondary Number:**	
Patient's Primary Care Physician's Name:	**Physician's Phone Number:**	

SCHEDULING: (START TIME is when you would like the patient in the chair. The doctor will typically arrive 30 minutes prior for setup)

First Available OR Date(s) Requested:	
Preferred Day(s) of the week, Mon-Sun:	
Appointment Start Time:	
Estimated Treatment Time:	

	Reason For Sedation:
	Nitrous Sedation failed
	Oral Sedation – Not a candidate/failed
	Severe dental phobia
	Overactive gag reflex
	Extensive surgical treatment
	Other:

	Dental Treatment:
	Pediatric/special needs treatment
	Crown/Bridgework/extractions/restorations
	Root canal/Pulp Treatment
	Implants/Periodontal Surgery
	All-on-4
	Other:

FINANCIAL INFORMATION:

☐ Fee for anesthesia discussed with patient
☐ Fee for anesthesia was NOT discussed with patient

Other relevant information for the anesthesiologist: _____