Vaughan Mills
SLEEP DENTISTRY
for children & adults

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Patient's Name: _____ Age: _____
FIRST LAST

Parent/Guardian(if child): _____ D.O.B.: DD / MM / YYYY

Phone: _____ Cell: _____

Email: _____ Medical Alerts: _____

Referral for Complete Treatment ☐ Specific Treatment ☐

_____

_____

Radiographs included ☐ Mailed ☐ E-mailed ☐ Sent with patient ☐

Remarks

_____

_____

_____

Referring Doctor: _____

Referring Dental Office: _____

Address: _____

_____

Telephone: _____

Email: _____

Translator Required for this Patient?

Yes ☐ No ☐