



Vaughan Mills
SLEEP DENTISTRY
for children



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Patient's Name: _____ Age: _____
FIRST LAST

Parent/Guardian: _____ D.O.B.: DD/MM/YYYY

Phone: _____ Cell: _____

Email: _____

Medical - Alerts / Allergies / Special Needs

Radiographs included E-mailed No Radiographs taken

Reason for Referral:

Referring Doctor: _____

Referring Dental Office: _____

Address: _____

Telephone: _____

Email: _____

Translator Required for this Patient?

Yes No

