



**SLEEP & SEDATION FOR DENTISTRY**  
*Children & Adults*

**Dr. Perry Vitoratos**  
 1-1222 Tranquille Road, Kamloops, BC V2B 3K2  
 Phone 250-554-2032 - Fax 250-554-1361  
 sunnyshoresdental@shaw.ca

**Patients Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's Address:** \_\_\_\_\_ **Referring Doctor:** \_\_\_\_\_  
**Patient's Phone#:** \_\_\_\_\_ **Doctor's Phone #:** \_\_\_\_\_  
**Birth Date:** \_\_\_\_\_ **Guardian Name:** \_\_\_\_\_

Tooth/Teeth to be evaluated:

				55	54	53	52	51		61	62	63	64	65				
18	17	16	15	14	13	12	11			21	22	23	24	25	26	27	28	
48	47	46	45	44	43	42	41			31	32	33	34	35	36	37	38	
				85	84	83	82	81		71	72	73	74	75				

**Special Care Individually Tailored to Each Patient's Needs**

**Reason for referral:**

- Anxious Children
- Anxious Adult
- Gag Reflex
- Difficult Local Anesthesia
- Other: \_\_\_\_\_

- X-Rays Mailed / Emailed
- X-Rays Sent with Patient
- Please take X-Rays

**Appointment:**

- Patient will contact you
- Contact Patient

**Primary Dental Insurance:**

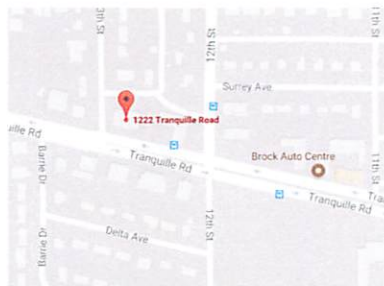
Insured: \_\_\_\_\_  
 Insured Date of Birth: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Carrier: \_\_\_\_\_  
 Group / Policy #: \_\_\_\_\_  
 ID#: \_\_\_\_\_  
 Division: \_\_\_\_\_ Dep#: \_\_\_\_\_

**Secondary Dental Insurance:**

Insured: \_\_\_\_\_  
 Insured Date of Birth: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Carrier: \_\_\_\_\_  
 Group / Policy #: \_\_\_\_\_  
 ID#: \_\_\_\_\_  
 Division: \_\_\_\_\_ Dep#: \_\_\_\_\_

**Special Instructions:**

Would you like to see patient back for recall appointment at your office:  Yes  No



**WE ACCEPT INSURANCE ASSIGNMENT**

*Thank You*

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