INFORMATION FOR ANESTHESIA CASES
To Be Completed by The Dental Office Only

PLEASE RETURN TODAY TO CONFIRM YOUR RESERVATION
Fax to 949-448-8858 or email to rdavies@cox.net

Dentist's Name:_____Phone #_____Fax:_____

Procedure Date Requested:_____ Patient Arrive Time:_____

Anesthesia Estimate Time (Surgery Time + 1 Hour) = _____hrs @ $500/hr

Please attach the patient's health history.

PATIENT CONTACT INFORMATION:

Title: Circle: Dr./Mrs./Ms./Mr.

First Name:_____ Last Name:_____

Address:_____

City:_____ State:_____Zip:_____

Date of Birth: _____

Phones: Home:_____Cell:_____Work:_____

Patient Email:_____

Please check if applicable:

☐ Wheelchair bound ☐ Obese ☐ Mentally challenged ☐ Under 13 years old

☐ Severe medical problems

The case is confirmed only when this is signed and faxed back to the dental office.

Signed:_____ Confirmed On:_____
Dr. Ron Davies