Awake or Asleep Dentistry

SLEEP DENTISTRY FOR ADULTS AND Kidz Ages 2+

I.V. Sedation and General Anesthesia

Patient Name: _____ Phone No: _____

Referring Dentist: _____ Phone No: _____

Date of Referral: _____ Email: _____

❑ Treatment requested: _____

_____

_____

❑ *Please provide complete care*
❑ *X-rays emailed to info@awakeorasleep.com*
❑ *X-rays to be taken* ❑ *X-rays sent with patient*
Please provide case report by ❑ *E-mail* ❑ *Mail*

www.awakeorasleep.com

325 Central Pkwy. W. #37
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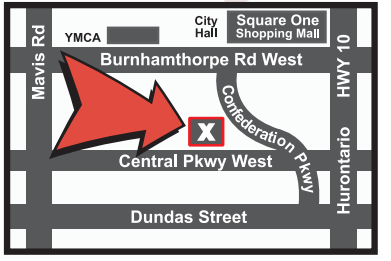
L5B 3X9

Dr. Andrey Golovanov, D.D.S.



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