



halcyon dental

sedation dentistry centers

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331.444.1185
halcyon.dental

Name: _____ Date: ____/____/____

Purpose for referral:

- One time treatment
- Comprehensive ongoing treatment
- Other: _____

Present conditions:

- Severe gag response
- Acute fear of needles
- Dental fear, specifically: _____
- Other: _____

Additional comments/reason for referral: _____

Referred by: _____

Phone number: _____

Note to patient: Please call us at **331.444.1185** to schedule your initial appointment at Halcyon Dental. Please refer to this card when speaking with our office. Also, remember to bring this referral card with you to your appointment. **Thank you!**