Dental Referral Form

From: _____ **To:** _____
Specialty: _____ **Specialty:** _____
Phone: _____ **Phone:** _____
Fax: _____ **Fax:** _____

Date: _____

Name of Patient: _____ **DOB:** _____

Name of Parent/Guardian (If applicable): _____

Address _____

_____

Email _____

Home Phone Number: _____ **Cell:** _____

Insurance: _____

Special Needs/Accommodations: _____

Introducing New Patient ☐ **Established Patient** ☐

_____Please Call Patient
_____Patient Will Call

Reason for Referral: **URGENT/Immediate Follow-up** ☐

_____ Patient's first dental visit
_____ Routine dental care
_____ Tooth Decay/ Early childhood caries
_____ Gum Disease
_____ Fractured/Avulsed tooth
_____ Oral Health Related Medical Condition: _____

☐ Please report findings/treatment back to referring provider
Additional Information: _____

Thank you.

Signature: _____
Date: _____

***Confidentiality Note**: This referral form is intended to be confidential and might be legally privileged. It is intended solely for the use of the addressee. If you are not the intended recipient, you are hereby notified that reading, copying, disseminating or distributing this information is strictly prohibited. If you have received this fax/email in error, please immediately return it to the sender and delete it from your system. Thank you.*

For Dental Office Use: *(Please report this information back to referring provider)*
Date of Appointment: _____
Diagnosis/Treatment: _____

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