



REFERRAL FORM

NOTE: Please forward chart notes, xrays, and latest treatment plan with this form.

Date of Referral: _____ Referring Dr/Clinic: _____

Dr phone: _____ Dr Fax: _____

Patient Name: _____ DOB: _____

Guardian Name: _____ DOB: _____

Relationship to child: _____ (If not a biological parent or stepparent, custody documentation is required.)

Phone #: _____ Email address: _____

Home address: _____

Patient Dental Insurance Information:

Subscriber Name: _____ DOB: _____

Carrier: _____ Employer: _____

Group#: _____ Contract/Policy#: _____

Reason for Referral:

☐ Toothache ☐ Decay ☐ Trauma ☐ Sedation ☐ Special Needs (please specify below)

Patient behavior: ___ F1 ___ F2 ___ F3 ___ F4 (F1 uncooperative, F4 very cooperative)

Behavior notes: _____

Please use below to relay any additional information:

*Patients with primary Medicaid are scheduled for an initial examination and are generally seen on a **treat-and-release basis** due to limited availability. This allows us to extend services to more patients.