

Advanced General Dentistry Clinic/GPR Program 1959 NE Pacific Street D-453 Health Sciences Center Box 356365 Seattle, WA 98195

PH: 206-685-8258 FAX: 206-616-8545

dental.washington.edu/agd

ALL FIELDS MUST BE COMPLETED IN ORDER TO PROCESS REFERRAL
PLEASE FAX REFERRAL TO 206-616-8545

Date of referral:

PLEASE FAX REFERRAL TO 206-616-8545						
PATIENT INFORMATION						
Patient Name				Date of Birth		
				!		
Address (street, city, state, and zip code)						
		T		T		
Home Phone		Cell Phone		E-mail		
Madical Incorpora (classes Pat)			Dental Incurrence and Describes One ID #			
Medical Insurance (please list)			Dental Insurance and Provider One ID #			
Guardian or Power of Attorney Contact Perso		on Name Contact Person Home Pho		ne Contact Person Cell Phone		
Contact Force		Sintano Sintano i indi		110	Someon Grown Figure	
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REFERRAL INFORMATION						
Reason for Referral (please list each tooth number individually, if applicable)						
Deferred D. (destes and/or facility name)			Office Phase		Office Form	
Referred By (doctor and/or facility name)			Office Phone		Office Fax	
Address (street, city, state, and zip code)					Office E-mail	
Address (street, only, state, and zip code)				Office E-mail		
PATIENT MEDICAL INFORMATION						
** Required for Referral **						
Primary Physician Name			Office Phone		Office Fax	
Address (street, city, state, and zip code)				Office E-mail		
Address (Street, City, State, and Zip Code)					Office E-mail	
Primary Medical Diagnosis Other M		Other Medical Conditions, in	ther Medical Conditions, including phobias		List All Medications	
Timely modical Biognosis		Caron modern constitutions, moderning principal				
		<u> </u>				
Wheelchair Bound: ☐ YES ☐ NO If yes, able to transfer from wheelchair?: ☐ YES ☐ NO				Oxygen Tanks: ☐ YES ☐ NO		
PATIENT RECORDS						
Date of Last MEDICAL Exam Workup Date of Last Complete DENTAL Exam				Discounting		
Date of Last MILDIOAL Exam Workup			TAL EXAIII	Please attach copy of Medical and Dental workup to this form.		
Current X-Rays: □ Pano		□ Ceph	□ PA	□ CT	□ MRI	
IMPORTANT: Originals preferred for film images. Digital images must be of diagnostic						
quality. Please mail all x-rays in advance to our address listed above.						
quanty. I loude man an x rays in devance to our dedices noted above.						