UW DENTISTRY
Faculty Practice

RESET FORM

1959 NE Pacific Street D-453
Health Sciences Center
Box 356365
Seattle, WA 98195

PH: 206-685-8258 FX: 206-616-8545
UW Dentistry Faculty Practice

REFERRAL FORM

DATE OF REFERRAL:

*** ALL FIELDS MUST BE COMPLETED IN ORDER TO PROCESS YOUR REFERRAL ***

PATIENT INFORMATION

Patient Name			Date of Birth
Address (street, city, state, and zip code)			
Home Phone	Cell Phone		E-mail
Medical Insurance (please list)		Dental Insurance and Provider One ID #	
Guardian or Power of Attorney	Contact Person Name	Contact Person Home Phone	Contact Person Cell Phone

REFERRAL INFORMATION

Reason for Referral (please list each tooth number individually, if applicable)

Referred By (doctor and/or facility name)	Office Phone	Office Fax
Address (street, city, 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

Primary Medical Diagnosis	Other Medical Conditions, including phobias	List All Medications
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	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.