UW DENTISTRY
Faculty Practice

RESET FORM

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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.