

Dental Referral Form

Dental eRx Office Confidential Medical Record

PATIENT INFORMATION

Last Name	First Name	Date of Birth	Phone	
Address		Insurance / Member ID	Chart #	Date of Visit

REFERRING PROVIDER

Provider Name	Practice / Office Name	Phone / Fax	Email	Date
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REFERRAL FOR

<input type="checkbox"/> Comprehensive Exam	<input type="checkbox"/> Limited / Emergency Exam	<input type="checkbox"/> X-Rays / Radiographs	<input type="checkbox"/> Cleaning / Prophylaxis
<input type="checkbox"/> Root Canal Therapy (RCT)	<input type="checkbox"/> Extraction	<input type="checkbox"/> Surgical Extraction / Impacted	<input type="checkbox"/> Filling / Restoration
<input type="checkbox"/> Crown / Bridge	<input type="checkbox"/> Implant Consultation	<input type="checkbox"/> Periodontal Treatment	<input type="checkbox"/> Oral Surgery Consult
<input type="checkbox"/> Oral Health Clearance — Surgery	<input type="checkbox"/> Oral Health Clearance — Military	<input type="checkbox"/> Oral Health Clearance — Medical	<input type="checkbox"/> Other (see notes)
Tooth / Teeth #(s)	Urgency	Appt Needed Within	Referred To

CLINICAL NOTES / REASON FOR REFERRAL

RELEVANT HISTORY & ATTACHMENTS

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Blood thinners / anticoagulants	<input type="checkbox"/> Antibiotic prophylaxis required
<input type="checkbox"/> Drug / latex allergy	<input type="checkbox"/> Bisphosphonate use	<input type="checkbox"/> Immunocompromised	<input type="checkbox"/> Radiation — head / neck
Allergies / Medications of Note	Radiographs Enclosed	Photos Enclosed	

SIGNATURE

Signature	Date
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