

### RECEIVING OFFICE

#### Dental ERx PLLC

St. Francis Bartlett Medical Arts Pavilion  
2996 Kate Bond Rd, Suite 311 | Bartlett, TN 38133  
(901) 646-0101

### HOW TO REFER

1. Complete all sections of this form.
2. Email referrals@dentalerx.com.
3. Attach relevant radiographs / records.
4. Patient may walk in or call to schedule.
5. Urgent cases: call (901) 646-0101 first.

### PATIENT INFORMATION

Last Name	First Name	Date of Birth	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	Insurance / Member ID	Chart #	Date of Visit
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### REFERRING PROVIDER

Provider Name	Practice / Office Name	Phone / Fax	Email
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Referral	<input type="text"/>		
<input type="text"/>			

### 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 below) |

Tooth / Teeth #(s)	Urgency	Appt Needed Within	Referred To (Provider / Dept)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### CLINICAL NOTES / REASON FOR REFERRAL

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

### 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Photos Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>

### SIGNATURE

Authorized Signature	Date
<input type="text"/>	<input type="text"/>