DENTAL REFERRAL FORM

SOURCE: General Anesthesia Dentistry

Referring Physician Information

Physician/Dentist name _____

Clinic name _____

Clinic address _____

City _____ State _____ Zip code _____

Phone _____ Fax _____

Contact name _____ Contact phone _____

Patient Information

Gender:

- ☐ Male
- ☐ Female

Name (first, middle and last) _____

Address _____

City _____ State _____ Zip code _____

Date of birth _____ Phone _____

Parent's name (if patient is a minor) _____

Legal guardian's name (if there is one) _____

Requested Appointment

Has a comprehensive exam been done? (A complete and thorough exam must be done in order to refer treatment to our facility. We only complete requested treatment.)

- ☐ Yes
- ☐ No

List all requested treatments (Ex. 5-do; 6-mo.; extractions 3, 4; scaling and root planning UL, LL, etc.)
(Please note, we cannot be considered a 'dental home' for patients due to our limited resources and availability.)

_____

_____

_____

Medical reason for general anesthesia dentistry referral (Must be something other than anxiety.)

_____

_____

Thank you for your referral to our office. Please email completed referral, x-rays with date, treatment plan and notes to dental@lakewoodhealthsystem.com.