DENTAL REFERRAL FORM

Referral Form Instructions

Please complete the fields by typing in the appropriate information, using the tab key to move from field to field. When you have completed the form, please click on the "Submit" navigation button at the bottom. You can save the information at any time and return with your email and password and print a copy for your records.

Referral Information

Doctor Information

Name of Practice: Lynbrook Dental Center

Name of Referring Doctor: Dr. Randy Jones

Phone Number: (516) 555-1212

Fax: (516) 555-1213

Email Address: RandyJonesDDS@gmail.com

Specialist Information

Name of practice to whom referral is directed: Rossein DDS, PC

Name of specific doctor to whom referral is directed: _____

Other Treating Doctors (optional)

Name and Specialty: _____

Name and Specialty: _____

Name and Specialty: _____

Patient Information

Full Name: Mrs. Sara Sedgewick

Phone Number: (516) 555-4578

Cell Phone Number: (917) 555-3546

Email Address: Sara.s2000@gmail.com

Date of Birth: 1-20-1970

Patient Status

Nature of Discomfort: ☐ None ☐ Mild ☑ Moderate ☐ Severe

Frequency of Discomfort: ☐ None ☑ Intermittent ☐ Constant

Scheduling: ☑ Emergency Treatment Requested ☐ Please schedule at your convenience ☐ Please call me before scheduling patient

Teeth:

Please click on the tooth # if the **tooth is missing**. Click on the box below the tooth number for any tooth that you would like us to examine.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
										☑					
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Deciduous:
Please click on the tooth # if the **tooth is missing**. Click on the box below the tooth number for any tooth that you would like us to examine.

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Reason for Referral

- ☑ Extraction of Teeth
- ☑ Dental Implant Consultation
- ☐ Soft Tissue Graft Evaluation/treatment
- ☐ Orthodontic Exposure of Impacted Teeth
- ☐ Biopsy
- ☐ Incision & Drainage
- ☐ Third Molar Evaluation and/or Removal
- ☐ Bone Augmentation Evaluation/treatment
- ☐ Pathology Evaluation and Treatment
- ☐ Evaluation of TMJ
- ☐ Frenectomy

Please evaluate tooth #11 for extraction and the possibility for immediate implant placement.

Radiographs or Clinical Photos

- ☐ Images are being mailed to your office
- ☐ Please take these records
- ☐ Patient will bring them
- ☑ Images are uploaded in this form below

I hereby certify that the foregoing information is accurate and complete.

Name of person submitting this form: Ms. Ginger Thompson

Signature: Electronically confirmed by IP Address 67.85.48.140 on 11-24-2015 at 05:02:08 EST