PATIENT REFERRAL FORM

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Please fax to *(507) 252-1445* or email securely to *info@rpdsmile.com*

PATIENT INFORMATION

Today's Date: ______________________ **Patient DOB:** ____________________

Patient's Name: __________________________________ **Gender:** ___________

Parent/Guardian's Name: ____

Address: ____
Street Apt.

____
City State ZIP

Telephone Number: ____

Email address: ____

☐ **Interpretor needed, language:** ______________________

Referring Dentist: _________________________ **Office Phone:** ________________

Please check all that apply:

- ☐ **Young Age**
- ☐ **Extensive Work Necessary**
- ☐ **Behavior managment**
- ☐ **Special Healh Care Needs**
- ☐ **Second Opinion**
- ☐ **Tooth/Facial Pain**

Treatment Completed:

- ☐ **Prophy (date):**
- ☐ **Radiographs taken (please forward/date):**
  - **Bitewings (date taken)** ________________
  - **Periapicals (date taken)** ________________
  - **Panoramic (date taken)** ________________
- ☐ **Restorations (tooth/date):**

Comments:

Return patient to referring office for routine care? ☐Yes ☐No

Appointment: Date ______________________ **Time** ______________________