Dental Referral Form

Date:_____/_____/_____

Patient Name:_____

Parent/Guardian:_____

Telephone: (_____)-_____-_____

DOB:_____/_____/_____

Medi-Cal #: _____

Primary Care Physician:_____

Telephone: (_____)-_____-_____

Reason for Referral (select one):

[ ] Patient Request [ ] Problem Focused Exam [ ] Patient Needs Preventative Treatment

[ ] Other (Please Specify in Notes)

Notes/Relevant History/Health Conditions:

_____

_____

_____

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_____

Additional Follow-up Instructions:

[ ] Please Report Back to PCP [ ] No Follow-up Needed

- Written
- By Phone

This form is not a medical release for dental treatment. Patient is under the care of the above healthcare provider.

Please Fax this form to 1-619-566-4464