Capitol Dental

Patient Referral Form

Date________________ Valid From ________________ To ________________ Referral #___________________

Specialty – Please select appropriate specialty and attach supporting documentation:

☐ **Oral Surgery**	☐ **Periodontics**	☐ **Endodontics**	☐ **Prosthodontics**	☐ **Pedo**
☐ PA of tooth	☐ FMX	☐ PA of tooth	☐ Pano/FMX	☐ X-rays
☐ PANO-multi exts/3rds	☐ PA – 1 area	☐ Medical history	☐ Medical history	☐ Chart notes
☐ Medical history	☐ Medical history	☐ Restorative Plan	☐ Perio charting	☐ Medical history
☐ Perio charting				

Patient Name _________________________________ Medical ID__________________ DOB ________________________

Address____ City/State______________________ Zip ______________________

Parent/Guardian Name___________________________ Home #___________________ Work # ________________________

PCD Name____ Office Phone ____________________________________

Office Address__________________________________ City/State_____________________ Zip ______________________

Referral Type (please select one): ☐ Limited for specific treatment ☐ Ongoing

Type of referral requested_________________________ CDT/ADA Code(s) _______________________________________

Clinical findings and Diagnosis____

____

Restorative treatment plan (please note that if final restoration is not covered, benefit referral will be denied)_________________

____

Prognosis ____

Special instructions (such as allergies, premed, prosthetic delivery) ____

____

Sedation Request (please select type): ☐ Oral Sedation ☐Nitrous ☐ IV Sedation ☐ GA

PCD Signature___________________________________

Date____

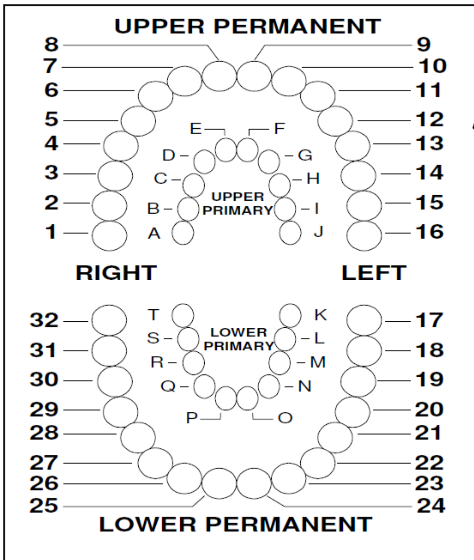
For Use By CDC Staff Only:

Referred To: ______________________________

Address: _________________________________

City/State ________________________________

Zip Code: ________________________________



Please place an "X" on tooth numbers that need treatment.

Revised 1/6/2020