

**Soft Touch Dental Patient Referral Form**

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**Specialty:**

**□ Oral Surgery** (No Pathology) □ **Other**

**\*We do not see referral patients under the age of 8 for IV Sedation\***

Patient Name:                                                                   DOB:                             Phone:

Insurance Co:                                                                          Ins ID#

Parent/Guardian Name:

PCD:                                                                             Ref Office Email:

Phone:                                              Fax:

Address:                                                                      City:                                              State:                Zip:

Reason for referral (be very specific, including diagnosis and clinical finding):

Special Instructions, including allergies/premed/delivery-prosthetics/interpreter/etc.:

\*We will contact the patient to set up the consultation\*

**PCD Signature**:                                                                           **Date**: