

**Soft Touch Dental Patient Referral Form**

**Danny Sadakah D.M.D**

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| 1727 NE 13th | 18773 SW Martinazzi Ave Ste. 100 |  |
| Portland, OR 97212 | Tualatin, OR 97062 |  |
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**Email:**[softtouchreferrals@gmail.com](mailto:softtouchreferrals@gmail.com) **Phone**: 503-249-1100 **Fax**: 541-746-7062

**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**: