Soft Touch Dental Patient Referral Form

Danny Sadakah, D.M.D.

1727 NE 13th Ave	907 NE 2nd Street	18773 SW Martinazzi Ave	967 N Cascade Dr.	1403 F Street
Portland, OR 97212	Gresham, OR 97030	Tualatin, OR 97062	Woodburn, OR 97071	Springfield, OR 97477
Fax: 503-249-2969	EMAIL REFERRALS TO:	softtouchreferrals@gmail.com	Phone: 503-249-1100	

Specialty:

☐ Oral Surgery ☐ Endo ☐ Other_____

Patient Name: _____ DOB: _____ Phone: _____

Insurance Co: _____ Ins ID # _____

Parent/Guardian Name: _____

PCD: _____ _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

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

_____

_____

_____

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

_____

_____

_____

PCD Signature _____ Date _____