Soft Touch Dental Patient Referral Form

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1727 NE 13th Portland, OR 97212	907 NE 2nd St Gresham, OR 97030	18773 SW Martinazzi Ave Ste. 100 Tualatin, OR 97062	967 N Cascade Dr. Woodburn, OR 97071	1403 F St. Springfield, OR 97477

Email: softtouchreferrals@gmail.com **Phone**: 503-249-1100 **Fax**: 541-746-7062

Specialty:

☐ **Oral Surgery** (No Pathology) ☐ **Endo** (Non-Molar) ☐ **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):

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

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We will contact the patient to set up the consultation

PCD Signature: ______________________ **Date**: ______________________