Community Smiles Dental
caring. serving. advocating.

DENTAL REFERRAL FORM
FAX to: 1-262-522-2828

Referring agency_____Date_____

Staff Contact Name_____ Phone Number_____

Staff Signature: _____(if section if left blank, patient will not be called.)

Patient First Name: _____ Last Name: _____

DOB: _____

Address: _____City/Zip_____

Phone: _____ Best Time to Call: _____
Community Smiles Dental Staff will CALL Patient to schedule an appointment

Medicaid: Yes ☐ No ☐

Forward ID #_____

Language Spoken Most Often: _____

The patient was screened and is being referred for:

Urgent Need ☐ Exam and Cleaning ☐

Referral Reason: (Chief Complaint/Comments)_____
_____
_____
_____

Mailing address: 210 NW Barstow St. #305 · Waukesha, WI 53188
Phone (262)522-7645, ext. 2250 · Fax (262)522-2828
www.communitysmiles.org