Community
Smiles **Dental**

DENTAL REFERRAL FORM

Please FAX to: Community Smiles Dental
For our Waukesha location fax to: 1-262-522-2828
For our Menomonee Falls location fax to: 262-502-0508

Referring agency_____Date_____

Staff Contact Name_____ Phone Number_____

Staff Signature: _____
(If this section is left blank, patient will not be contacted)

Patient First Name: _____ Patient Last Name: _____
DOB: _____
Address: _____ City/State/Zip: _____
Phone: _____ Best time to call: _____

Does the patient have Medicaid insurance? Please circle: Yes No
If yes, Forwardhealth ID #: _____
Language spoken most often: _____

The patient was screened and is being referred to CSD for:
Please circle one: Urgent Need OR Exam/Cleaning
Referral Reason/Chief Complaint/Comments: _____
_____
_____
_____
_____

Waukesha Clinic address: 210 NW Barstow Street, Suite 305 Waukesha, WI 53188
Menomonee Falls Clinic address: N81W15062 Appleton Avenue Menomonee Falls, WI 53051