Dental Access Partnership Form

Referring Agency or Person Referring Below:

Professional First and Last Name: ______________________ **Telephone:** ______________

Agency and/or Doctor's Name who is referring: ______________________________

Patient Information

Legal First and Last Name: ______________________ **Date of Birth:** ______________

Parent/Guardian Name: (if minor): ______________________ **Telephone:** ______________

Insurance Name: ______________________ **Policy Number:** ______________________

Do you have a regular dentist? **Yes** **No** **Dentist Name & Location** ______________________

Last time visited to a dentist: ______________ **Where:** ______________________

What was it for (circle): **Problem Focused** **Cleaning/ Check-up** **Other:** ______________

Are you involved with any other OHF programs: **Yes** **No** **If so which program?** ______________

Do you have any chronic disease?
(Diabetes, Heart Condition, Etc) ______________________________

Have you been in FOSTER CARE? **Yes** **No** **When?** ______________________

Are you disabled? ______________ **Are you pregnant?** ______________

Reason for referral today: ______________________________

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Please email or fax to:
info@ohfspokane.org I Fax: (509) 534-1392

Office Use Only: