DFW Dental Team

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Office: (214) 613-5110 Fax: (214) 613-5118
Team@DFWDentalTeam.com

New Patient Referral

Referring Provider

Office Name: _____ Telephone: _____

Doctor Name: _____ Signature: _____

Patient Information

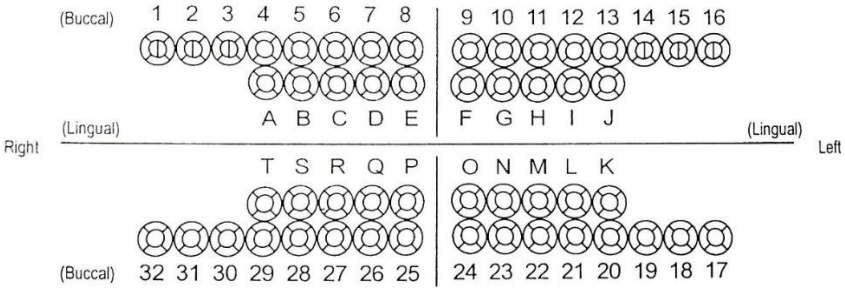
Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Name: _____ Date of Birth: _____

Telephone #1: _____ Telephone #2: _____

Indicate Teeth Requiring Treatment

☐ 1–2 Teeth ☐ 3–4 Teeth ☐ 5–8 Teeth ☐ 9+ ☐ Other / Details: _____



Required Information (circle answers)

Failed conscious sedation (e.g. nitrous oxide and/or oral sedatives)?	**YES**	**NO**
Does patient wear braces or device that could interfere with treatment?	**YES**	**NO**

Reason for Referral

☐ Unable to cooperate / lack of physical or emotional maturity (please explain): _____

☐ Patient requires medical supervision or has an Intellectual & Developmental Disability or special healthcare needs

☐ Additional Notes: _____

If Patient has Medicaid, please complete:

☐ DentaQuest Interim Care Transfer (ICT) Faxed to (888) 261-1736

☐ MCNA Referral Submitted Through Online Portal MCNA Referral #: _____

Email or **Fax with X-Rays and treatment plans** to
Email: **Team@DFWDentalTeam.com** or Fax: **(214) 613-5118**