ECU SCHOOL OF DENTAL MEDICINE REFERRAL FORM

PHONE: 252-737-7834 FAX: 252-737-0221 ADDRESS: 1851 MACGREGOR DOWNS ROAD MS 701 GREENVILLE, NC 27834

REFERRING DENTIST INFORMATION

Dentist's Name:	**Practice Name:**
Practice Address:	
Practice Phone Number:	**Practice Email Address:**

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)**
					Single / Mar / Div / Sep / Wid

Is this patient's legal name?	**If not, what is the legal name?**	**(Former name):**	**Birth date:**	**Age:**	**Sex:**	
❑ Yes ❑ No			/ /		❑ M	❑ F

Street address:	**Social Security no.:**	**Home phone no.:**
		( )

P.O. box:	**City:**	**State:**	**ZIP Code:**

GUARANTOR INFORMATION

***Guarantor's First Name:**	**Guarantor's Last Name:**	***Birth date:**	***Subscriber's S.S. no.:**
		/ /	

Guarantor's Martial Status (circle one)	**Guarantor's Sex**		**Guarantor's Home Phone number**	**Guarantor's Mobile Phone number**
Single / Mar / Div / Sep / Wid	❑M	❑F	( )	( )

Guarantor's Address:		
City:	**State:**	**Zip Code:**

Patient's relationship to Guarantor:	❑ Self	❑ Spouse	❑ Child	❑ Other

REASON FOR REFERRAL

❑ Medically Complex Patient. Send copy of medical history	❑ Dental Clearance (e.g.: pre-transplant, radiation, surgery, or chemotherapy)	❑ Special Needs Patient Send copy of medical history
❑ Oral Lesions/Oral Medicine	❑ Orofacial pain (e.g.: TMD)	❑ Prosthodontics
❑ Periodontology	❑ General Dentistry	❑ Endodontics
❑ Oral Surgery	❑ Pediatric Dentistry	❑ Dental Radiology

Please provide specifics about the condition, including current signs and symptoms, and provide your diagnosis.

What specific treatment you are referring for us to perform?

What treatment has been provided to date at your office?

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Significant medical history:
FOR ENDODONTIC REFERRALS COMPLETE THE FOLLOWING:
Cold test results:
Percussion sensitivity:
Tooth slooth test:
Swelling: Yes or No If yes, describe:
Provisional Diagnosis- Pulpal: Periapical: Other:
Treatment provided to tooth: ___ None ___ Partial Caries Excavation ___ Complete Caries Excavation **Restoration Placed – Describe:**
Was there a pulpal exposure: ___ Yes ___ No ___ N/A **Was any of the following tx completed:** **___ Pulpectomy ___Pulpotomy ___ Direct Pulp Cap ___Indirect Pulp Cap** **Other – explain:**
Antibiotic therapy started: Yes or No **If Yes, which antibiotic regimen was prescribed:**
Radiographic Images: Please send all images and dates
What is the date of the last set of BWX:
What is the date of the last Panoral Radiograph and FMX:
What is the date of the last PA:
Note other significant images and dates taken:
What is the date of the last prophy or perio maintinence:
Please rate, using the Frankl Scale,the patient's anticipated level of cooperation for treatment:
___ Rating 1: Definitely negative: Refusal of treatment, crying forcefully, fearfulness, or any other overt evidence of extreme negativism **___ Rating 2: Negative: Reluctance to accept treatment, uncooperative behavior, some evidence of negative attitude but not pronounced (i.e. sullen, withdrawn), resistance to receiving dental anesthetic or other treatment** **___ Rating 3: Positive: Acceptance of treatment, at times cautious, willingness to comply with the dentist, at times with reservation but follows the dentist's directions cooperatively.** **___ Rating 4: Definitely positive: Good rapport with dentist, interested in dental procedure, laughing and enjoying the situation**
Please provide any additional information you feel is pertenant to the treatment of this patient:
Please provide all of the patient's current radiographs. Digital radiographs are preferred. *Email images to **SODM-FP-REFERRAL@ECU.EDU**. Include in the email note the patient's name and date of birth, and dates of radiographs. If the patient is 15 years or below, please email our pediactric department at **SODM-OP-REFERRAL@ECU.EDU**.*

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MEDICAL INSURANCE INFORMATION
PATIENT OR GUARANTOR: COMPLETE AND BRING TO YOUR APPOINTMENT

Please provide copies of all insurance cards front and back. * Required fields*

Does the patient have medical insurance?	❑ Yes ❑No If yes, please complete below.				
***Subscriber's name:**	***Subscriber's S.S. no.:**		***Birth date:**	***Group no.:**	***Policy no.:**
			/ /		
Subscriber's Martial Status (circle one)	**Subscriber's Sex**		**Subscriber Home Phone number**		**Subscriber Mobile Phone number**
Single / Mar / Div / Sep / Wid	❑M	❑F	( )		( )
Subscriber Street Address:					
P.O. Box:	**City:**		**State:**		**Zip Code:**
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary medical insurance (if applicable):					
Subscriber's name:	**Subscriber's S.S. no.:**		**Birth date:**	**Group no.:**	**Policy no.:**
			/ /		
Subscriber's Martial Status (circle one)	**Subscriber's Sex**		**Subscriber Home Phone number**		**Subscriber Mobile Phone number**
Single / Mar / Div / Sep / Wid	❑M	❑F	( )		( )
Subscriber Street Address:					
P.O. Box:	**City:**	**State:**	**Zip Code:**		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Pre-Authorization Number Primary or Secondary Insurance			**Pre-Authorization Expiration Date**		

DENTAL INSURANCE INFORMATION

Please provide copies of all insurance cards front and back. *Required Fields*

Does the patient have dental insurance?	❑ Yes ❑No If yes, please complete below.				
***Subscriber's name:**	***Subscriber's S.S. no.:**		***Birth date:**	***Group no.:**	***Policy no.:**
			/ /		
Subscriber's Martial Status (circle one)	**Subscriber's Sex**		**Subscriber Home Phone number**		**Subscriber Mobile Phone number**
Single / Mar / Div / Sep / Wid	❑M	❑F	( )		( )
Subscriber Street Address:					
P.O. Box:	**City:**		**State:**		**Zip Code:**
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary Dental Insurance (if applicable):					
Subscriber's name:	**Subscriber's S.S. no.:**		**Birth date:**	**Group no.:**	**Policy no.:**
			/ /		
Subscriber's Martial Status (circle one)	**Subscriber's Sex**		**Subscriber Home Phone number**		**Subscriber Mobile Phone number**
Single / Mar / Div / Sep / Wid	❑M	❑F	( )		( )
Subscriber Street Address:					
P.O. Box:	**City:**	**State:**	**Zip Code:**		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Please send copy of medical and dental insurance cards with referral

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