ECU SCHOOL OF DENTAL MEDICINE REFERRAL FORM – PEDIATRIC DENTISTRY AND ORTHODONTICS

PHONE: 252-737-7834 FAX: 252-737-7187 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	❑ Dental Clearance (e.g.: pre-transplant, radiation, surgery, or chemotherapy)	❑ Special Needs Patient
❑ Oral Lesions/Oral Medicine	❑ Orofacial pain (e.g.: TMD)	❑ Prosthodontics
❑ Periodontology	❑ General Dentistry	❑ Endodontics
❑ Oral Surgery	❑ Pediatric Dentistry	❑ Dental Radiology

What specific treatment you are referring for us to perform? Please provide specifics including diagnosis.

Radiographic Images:

What is the date of the last set of BWX:	**What is the date of the last Panoral Radiograph:**
Note other significant images and dates taken:	

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Please comment on the patient's current medical needs:

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to accept treatment, uncooperative behavior, some evidence of a negative attitude but not pronounced (i.e., sullen, withdrawn).
___ 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 the dentist, interested in the dental procedures, laughing and enjoying the situation.

Treatment provided to date at your office:

Please provide any additional information you feel is pertinent to the treatment of this patient:

Please provide the patient's current radiographs. Digital radiographs are preferred.
*Email images to **SODM-OP-REFERRAL@ECU.EDU**. Include in the email note the patient's name and date of birth, and dates of radiographs.*

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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	
Pre-Authorization Number required for Sickle Cell Fund			**Pre-Authorization Expiration Date**		