Chu DENTAL GROUP

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SPECIAL CARE DENTISTRY

Henry Chu, D.D.S., P.A.

Referring Provider Date: _____

Office Name: _____ Phone: _____

Doctor Name: _____ Signature: _____

Patient Information

Patient Name: _____ D.O.B.: _____

Parent/Guardian: _____ Phone: _____

Previous Experience in Dental Office (cooperative/uncooperative/etc.): _____

_____

X-Rays: ☐ Not able to take ☐ Bitewings ☐ Panos

If taken: ☐ Patient will bring ☐ We will send

Dental concerns/diagnosis (If known): _____

Required Information

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 due to extreme anxiety, lack of physical or emotional maturity (please explain situation): _____

☐ Patient requires medical supervision or has an intellectual & Developmental Disability or special healthcare needs. _____

_____

☐ Additional Notes: _____

If Patient has Medicaid, please complete:

☐ Dentaquest #: _____

☐ MCNA Referral #: _____

We would like to thank you for your referral and entrusting your patient's care with our office. Please call us if you have any questions.

Feel free to fax or e-mail us your referrals.

E-mail: specialcaredentistry@chudentalgroup.com

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