St. Vincent DePaul Dental Clinic Date:\_\_\_\_\_\_\_\_

Vincentian Referral Form

420 W. Watkins Rd Phoenix, AZ 85003

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Need (circle any that apply):

* Pain
* Infection
* Tooth removal
* Appearance

Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brief Medical History

* High Blood Pressure [yes] [no] Is it controlled [yes] [no]
* Diabetes [yes] [no] Is it controlled [yes] ]no]
* Heart Conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have health insurance [yes] [no]

District #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Conference:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Conference Liaison: Phone/Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by:

|  |
| --- |
| CONFERENCE PRESIDENT: Date: |

|  |
| --- |
| DISTRICT PRESIDENT: Date: |

**\*\*If a Patient misses their first new patient appointment, no further services are provided.**

**\*\*Patients who miss two appointments will not receive further services.**

Please scan and email all documents to [**sedwards@svdpaz.org**](mailto:sedwards@svdpaz.org)

**Revised March 2018**