

Metro Denver Dental Foundation Smile Again Program™ Patient Referral Request

Date: _____

Advocate Name: _____

Requesting Organization: _____

Contact Preference: Phone _____ Fax _____ or Email _____

Candidate/Patient Information:

Name: _____ Date of Birth: _____ Sex: Male or Female (circle one)

Race (optional): _____ Phone: _____ (must have reliable contact number)

Address: _____

City: _____ State: _____ Zip Code: _____

1) Is candidate able to utilize transportation? Y or N – If yes, specify: public transportation or private vehicle

2) Is candidate fluent in English? Y or N – If not, list language(s): _____

3) Has the candidate ever seen a dentist? Y or N – If so, when?: _____

4) Does this candidate have Medicaid? Y or N – If so, what type?: _____

5) Does this candidate have a past history of substance abuse? Y or N – If so, what type?: _____

6) Are you employed? Y or N (circle one) – If so, state place of employment: _____

Nature of dental problem:

1) Primary concern: (check all that apply)

- Pain
- Dental function impaired (i.e. can't chew or bite, difficulty speaking)
- Appearance issue

2) Type of injury:

- Trauma resulting from domestic violence attack (i.e. knocked out/chipped teeth or damaged dentures)
- Issues resulting from neglect (i.e. gum disease, dental decay)

3) Description of problem:

PLEASE COMPLETE THIS ENTIRE FORM. INCOMPLETE INFORMATION WILL RESULT IN PLACEMENT DELAYS.

Conditions Present: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Missing Teeth – How many? _____ | <input type="checkbox"/> Sensitivity/Pain |
| <input type="checkbox"/> Broken Teeth (Cracked or Chipped) – How many? _____ | <input type="checkbox"/> Needs teeth pulled – How many? _____ |
| <input type="checkbox"/> Loose Teeth – How many? _____ | <input type="checkbox"/> Jaw pops |
| <input type="checkbox"/> Bleeding/Swelling Gums | <input type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Decay | <input type="checkbox"/> Severe Discoloration |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Other _____ |

Special Circumstances:

Please return...

By Mail: Attn: CONFIDENTIAL/Smile Again, MDDS, 3690 South Yosemite Street, #200, Denver, CO 80237 By Fax: (303) 488-0177