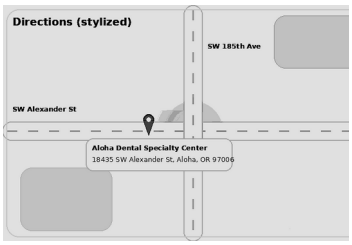
ALOHA DENTAL
SPECIALTY CENTER
Referral & Specialty Services



503-822-0096
alohadentalspecialty.com
info@alohadentalspecialty.com

18435 SW Alexander St
Aloha, OR 97006

REFERRAL FORM

REFERRED SPECIALTY (check):

☐ Dental Implants ☐ Oral Surgery/Extractions ☐ Endodontics (RCT) ☐ Pediatric ☐ Orthodontics / Invisalign ☐ Airway / Sleep ☐ TMJ / TMD

☐ Botox / Fillers ☐ CBCT Scan ☐ Restorative ☐ Dentures/Prosthesis ☐ Emergency ☐ Other: _____

Patient Name: _____ **DOB:** _____
Patient Phone: _____ **Email:** _____
Referring Doctor: _____ **Office Phone:** _____
Office/Practice: _____ **Insurance:** _____

TOOTH / AREA: _____ ☐ Consult only ☐ Treat & Return ☐ Co-manage

Upper (1–16)
Mark tooth/area as applicable

Lower (17–32)

CLINICAL FINDINGS (check):

☐ Pain ☐ Swelling ☐ Infection/Abscess ☐ Sinus tract ☐ Trauma ☐ Fracture/Crack ☐ Antibiotics Rx'd

☐ Previous RCT ☐ RCT started ☐ Pulp exposure ☐ PA lesion ☐ Resorption ☐ Temp crown ☐ Recent restoration

☐ Wisdom tooth ☐ Surgical/impacted extraction ☐ Root tip retained ☐ Implant consult ☐ Bone graft/Sinus lift ☐ Implant complication ☐ Snoring / suspected OSA

☐ TMJ pain/clicking ☐ Limited opening ☐ Bruxism/clenching ☐ Ortho/Invisalign consult ☐ Pediatric referral ☐ Sedation interest ☐ Premed needed

ATTACHMENTS: ☐ PA/BWX ☐ Pano ☐ CBCT (DICOM) ☐ Photos ☐ IO Scan ☐ Perio Chart ☐ Other: _____

CLINICAL NOTES / REQUEST:

_____
_____
_____
_____
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