



OFFICE USE

Received: _____

Contacted: _____

Appt Date: _____

Telephone: 262-379-1401 / Fax: 262-379-1095 / Email: info@openarmsfreeclinic.org

Primary Location: 205 E. Commerce Ct, Elkhorn, WI 53121

Dental Referral Form

Patient Name:	DOB:
Primary Phone:	Secondary Phone:
Address:	
City/State/Zip:	
Primary Language:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____
Emergency Contact:	Relationship:
Phone Number:	Referring School/Agency:

How long has it been since you have seen a dentist? _____

Have you ever had problems with prior dental treatment: ☐ Yes ☐ No

Primary concern: _____ When did it start: _____

Location of Pain: <input type="checkbox"/> Upper Right <input type="checkbox"/> Upper Left <input type="checkbox"/> Lower Right <input type="checkbox"/> Lower Left
Discomfort: <input type="checkbox"/> On/Off <input type="checkbox"/> Constant
Sensitivity to (check all that apply): <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Pressure <input type="checkbox"/> Sweet <input type="checkbox"/> Wake from sleep <input type="checkbox"/> Swelling <input type="checkbox"/> Fever <input type="checkbox"/> Trauma to Area
Current Health Insurance Status: <input type="checkbox"/> Uninsured <input type="checkbox"/> Forward Health/BadgerCare <input type="checkbox"/> Medicare <input type="checkbox"/> Veterans Benefits <input type="checkbox"/> Employer Insurance
Current OAFB Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No

I give my permission for Open Arms Free Clinic to contact me. ☐ Yes ☐ No

***A parent/guardian must accompany any minor child to the first appointment.**

Signed: _____ Date: _____

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