OFFICE USE
Received: _____
Contacted: _____
Appt Date: _____

OPEN ARMS FREE CLINIC
CLINICA GRATUITA

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: ☐ Male ☐ Female ☐ _____
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: ☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left

Discomfort: ☐ On/Off ☐ Constant

Sensitivity to (check all that apply): ☐ Hot ☐ Cold
☐ Pressure ☐ Sweet ☐ Wake from sleep ☐ Swelling ☐ Fever ☐ Trauma to Area

Current Health Insurance Status:
☐ Uninsured ☐ Forward Health/BadgerCare ☐ Medicare ☐ Veterans Benefits
☐ Employer Insurance

Current OAFC Patient: ☐ Yes ☐ 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: _____