



Health Centered Dentistry

1400 Benson Blvd, Suite 150 | Anchorage, Alaska 99503 | O: 907.276.4537 | F: 907.276.4538
info@hcdentistry.com | www.hcdentistryak.com

PATIENT REFERRAL

Name: _____

Date: _____

Appointment Time/Date: _____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

FOR REFERRING DOCTOR:

This patient is being referred for the evaluation of the following reason(s):

- | | |
|--|---|
| <input type="checkbox"/> Amalgam Removal | <input type="checkbox"/> Removable Prosthodontics |
| <input type="checkbox"/> Clifford Testing (Allergy testing for dental materials) | <input type="checkbox"/> Sedation Dentistry |
| <input type="checkbox"/> Gum Health Evaluation | <input type="checkbox"/> Dental Anxiety |
| <input type="checkbox"/> Chao Pinhole® Tissue Graft | <input type="checkbox"/> Complex Dental Needs |
| <input type="checkbox"/> Periodontal Disease Evaluation | <input type="checkbox"/> Difficulty Attaining Numbness |
| <input type="checkbox"/> Soft Tissue Graft | <input type="checkbox"/> Fear of Needles |
| <input type="checkbox"/> Missing Teeth Replacement Options | <input type="checkbox"/> Highly Sensitive Teeth |
| <input type="checkbox"/> Bridge | <input type="checkbox"/> Previous Negative Dental Experience |
| <input type="checkbox"/> Implant (Titanium) | <input type="checkbox"/> Strong Gag Reflex |
| <input type="checkbox"/> Implant (Zirconium) | <input type="checkbox"/> Sleep Apnea Appliance |
| <input type="checkbox"/> Partial | <input type="checkbox"/> TMD/TMJ Occlusal Evaluation |
| <input type="checkbox"/> Oral Cancer Screening | <input type="checkbox"/> Clicking/Popping in joints |
| <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Congestion/Stuffiness in the ears |
| <input type="checkbox"/> Ozone treatment | <input type="checkbox"/> Cracking, chipping dental restorations |
| <input type="checkbox"/> Injection | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Nasal Suflation | <input type="checkbox"/> Limited movement/Locking jaw |
| <input type="checkbox"/> Oil/Cream | <input type="checkbox"/> Neck, shoulder, back pain |
| <input type="checkbox"/> Tray | <input type="checkbox"/> Other: _____ |

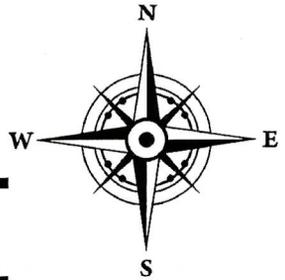
COMMENTS: _____

- Please call me before proceeding with treatment. I have sent radiographs for your evaluation

Referring Doctor: _____ Date: _____

Referring Doctor Phone #/Email: _____

FOR REFERRED PATIENT:



Hours of Operation:

Monday: 8am – 5pm
Tuesday: 10am – 7pm
Wed – Thurs: 8am – 5pm
Friday: 7am – 4pm
2nd Saturday: 8am – 1pm

Doctors:

Clint Henrie, DMD
Kent Marchant, DMD
Greg Bragiel, DDS
Michael Madsen, DDS

Contact Information:

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W: www.hcdentistryak.com

PRIOR TO YOUR APPOINTMENT

Please visit us online to complete your new patient paperwork. This link is found at hcdentistryak.com/Patient-Information/. Click on the “Adult New Patient Forms” or “Child New Patient Forms” to complete all the new patient paperwork. You can also request records from a previous office by completing the forms under the “Records Release Form” button.

WHAT TO EXPECT AT YOUR APPOINTMENT

At Health Centered Dentistry, our goal is to ensure our patients receive the best care and understand their recommended treatment. When you come to our office, you will meet with one of our doctors and their assistant to help ascertain your needs. This includes reviewing your medical history in detail. You will receive a treatment plan with estimates for your dental insurance (if applicable). Same-day treatment may be possible dependent on the treatment you were referred to our office for and time.

We welcome you to our practice and look forward to the opportunity to serve you!

Sincerely,

Health Centered Dentistry Team