Brown Mobile Dental
PO Box 122295
Fort Worth, Texas 76121
817-335-5555

Dental Referral Form

Date: _____ Facility Name: _____ Room #: _____

Resident Name: _____ Gender: _____ Date of Birth: _____

SSN: _____ Medicaid #: _____

Natural Teeth: YES NO

In Pain: YES NO

On Hospice: YES NO

Attending Physician: _____ Hospice Provider: _____

Person Making Referral: _____ Title: _____

Is this patient a full vendor? YES NO

If the patient is a full vendor, who is paying for treatment? (Circle one below):

Responsible Party Nursing Facility

For ALL Referrals
Please fax/mail the following with this completed form:
-Current Face Sheet -Diagnosis and Medications List
-Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

For Medicaid Patients with Applied Income
Please fax/mail completed H1263B form with all required signatures.
Note that we MUST have the original copy of this form before we begin treatment.

For Private Pay
Please fax/mail Brown Mobile Dental Private Pay Consent Form.
We must receive payment for the initial exam before we can schedule the exam.

Failure to provide accurate information may result in nursing home liability for dental fees.