



SEATTLE  
SPECIAL CARE DENTISTRY™

Bryan Williams, DDS, MSD

Donna Quinby, DMD, MSD

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Date of Referral: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone (primary): \_\_\_\_\_ Phone (alternate): \_\_\_\_\_

Referring Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Contact phone/E-mail: \_\_\_\_\_

Referral for a:

- Healthy Child     Child with Developmental Disability/Special needs     Child with Complex Medical History

Additional Medical History and Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dental Treatment Needs Identified:

\_\_\_\_\_  
\_\_\_\_\_

Orthodontic Concerns     Periodontal Concerns

Map/directions on reverse

*Thank you for your referral!*

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[www.seattlespecialcaredentistry.com](http://www.seattlespecialcaredentistry.com)

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