



SEATTLE
SPECIAL CARE DENTISTRY™

Bart Johnson, DDS, MS

Amy Winston, DDS

Patient Name: _____

Date: _____ Phone (primary): _____

Hosp #: _____ Phone (alternate): _____

Birth date: _____

Referring Provider: _____

Contact phone/E-mail: _____

Urgency: < 48 hrs (please call SSCD) < 2 wks Routine

Reason for referral:

Additional History and Information:

- Medically complex _____
- Developmentally Disabled/Special needs _____
- Transplant _____
- Radiation Oncology _____
- Medical Oncology _____
- Hemophilia _____
- IV sedation/GA _____
- Other _____

Map/directions on reverse _____

Thank you for your referral!

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