

Comfy Denture & Hearing Clinic

30818 Pacific Hwy S, Federal Way, WA 98003
 Phone: 253-839-1505
 Fax: 253-941-3896
 E-mail: comfyfedway@gmail.com

308 Washington Ave S., Kent, WA 98032
 Phone: 253-981-3917
 Fax: 253-981-3926
 E-mail: comfykent@gmail.com

18802 Mountain View Dr. E, Bonney Lake, WA 98391
 Phone: 253-750-4164
 Fax: 253-987-7252
 Email: comfybonney@gmail.com

Referral Form – Please complete all applicable sections

Today's date: _____ Patient's Name: _____

Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Insurance Name and ID Number: _____

- Mark missing teeth with //
- Mark teeth that will be extracted with X

MOLARS			BICUSPIDS			ANTERIOURS			BICUSPIDS			MOLARS			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Does the patient need further extractions?

Yes No

If yes, list tooth numbers: _____

Please check all that apply:

DENTURES

- Upper – Complete Partial
 Lower – Complete Partial

IMPLANT DENTURES

- Upper – Complete
 Lower – Complete

HEARING

- Hearing Evaluation
 Hearing Aids

MAXILLOFACIAL PROSTHETICS

- Ear
 Nose
 Eye
 Obturator
 Palatal Lifting Device
 Radiotherapy Mask

OTHER SERVICES

- Occlusal Guard
 Teeth Whitening
 Snoring Oral Device
 Other: _____

Referred Clinic Name: _____

Important: Please ensure the referral is sent to the correct office. Referrals may be faxed or emailed. Thank you! 😊