

EASTERN OKLAHOMA DONATED DENTAL SERVICES

Vulnerable Population Program

3741 South Peoria

Tulsa, Oklahoma 74105

IN TAKE REFERRAL FORM

(Please print or type)

*****Accepted through mail only*****

Date: _____

Referring Agency/Organization: _____

Agency Telephone #: _____

Form Completed By (if other than client): _____

Name of Client: _____

Home Phone#: _____ **Cell Phone#:** _____

Male **Female** **Birthdate:** _____

Address: _____

City, Zip Code: _____

County: _____

Client Social Security #: _____

Race (circle one choice): African American / Asian / Caucasian / Hispanic / Latino /

Oriental / Native American / Other

Contact Person: _____ **Relationship:** _____ **Phone:** _____

Health Problems: _____

Annual Income (total household): _____ **Total # persons living in household:** _____

Sources & Monthly Amount of Income (SS, SSI, SSD, DHS, etc): _____

Do you receive food stamps? Yes/No Please list amount: _____

List Monthly Expenses: Rent/Mortgage: _____ **Food:** _____ **Medication:** _____

Description of Dental Problem/Request: _____

Do you need any remaining teeth extracted in order to have dentures/partials? _____

Do you have Medicaid, (also known as) Soonercare? Yes or No

***I am aware that when submitting this application for services through EODDS I am giving EODDS permission to share my personal information with the volunteer dental offices and funding support sources.**

Signature: _____

******Back Page for EODDS office use only******

DATE APPROVED: _____

DATE DENIED: _____

DR. REFERRED TO: _____

DR'S: PHONE # _____

APPT. DATE/TIME: _____

SPECIALIST REFERRED TO: _____

SPECIALIST APPT. DATE/TIME: _____

LAB REFERRED TO: _____ **PHONE#** _____

LETTER SENT DATE: _____