



REFERRAL FOR TREATMENT

PATIENT INFORMATION

Patient Full Name: Date of Birth: MM / DD / YYYY
Phone Number: Date of Referral: MM / DD / YYYY
Email Address:

DENTAL INSURANCE INFORMATION: PRIMARY INSURANCE PROVIDER

Insurance Holder Full Name: Date of Birth: MM / DD / YYYY
Employer Company Name: Carrier:
IPolicy/Plan #: ID #:

DENTAL INSURANCE INFORMATION: SECONDARY INSURANCE PROVIDER

Insurance Holder Full Name: Date of Birth: MM / DD / YYYY
Employer Company Name: Carrier:
Policy/Plan #: ID #:

REFERRING DENTIST INFORMATION

Dentist Name: Clinic Name:
Phone Number: Email Address:

REFERRAL REASON IN DETAIL

Please circle the teeth of interest for examination or treatment:

Table with 2 rows and 2 columns of tooth numbers (18-11 and 21-28 in top row; 48-41 and 31-38 in bottom row).

- Extractions
- Bone Grafting / Socket grafting / Ridge preservation
- Sinus Lift (Crestal / Lateral)
- Implant Surgery (Delayed / Immediate)
- Implant Provisionalization (Temporary)
- Other Treatments:
- Final Prosthetic Restoration (Implant Crown)
- Full Arch Rehabilitation (Locator Overdenture, All-on-X)
- Connective Tissue / Free Gingival Grafting
- Cone Beam CT Scan (10x10 FOV)
- Sedation (circle one): IV Sedation | Oral Sedation

FURTHER INSTRUCTIONS

Blank lines for further instructions.

MEDICAL CONDITIONS

Blank lines for medical conditions.

- Please check all that apply:
- Please call Patient Dental insurance information sent separately
 - X-ray imaging is sent by (circle one): E-mail | With the patient | In mail