

## PATIENT INFORMATION

Date: \_\_\_/\_\_\_/\_\_\_

Insurance: \_\_\_\_\_  Discount plan \_\_\_\_\_%  No Insurance

Account #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referred From Office: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referring Doctor Name: \_\_\_\_\_

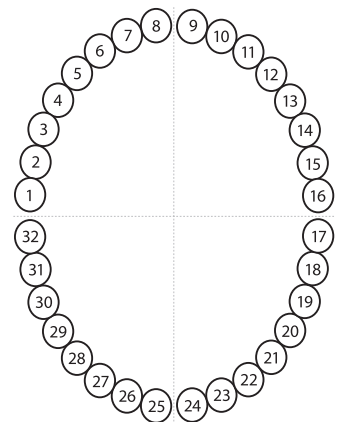
Refer To: (please circle one)

**Endo**

**Perio**

Services Needed:

ADA CODE	DESCRIPTION	TOOTH	QUAD



Narrative: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Referring Doctor Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

### TREATMENT AUTHORIZATION

Date: \_\_\_/\_\_\_/\_\_\_ Auth #: \_\_\_\_\_

Insurance Contact: \_\_\_\_\_ Ext.: \_\_\_\_\_

Approved      Denied      Not Approved      Pending

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Staff Member: \_\_\_\_\_

Periodontist: Dr. Nicole Besu • Endodontist: Dr. Scott Shwedel