



Dental Specialty Center of Homestead

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)

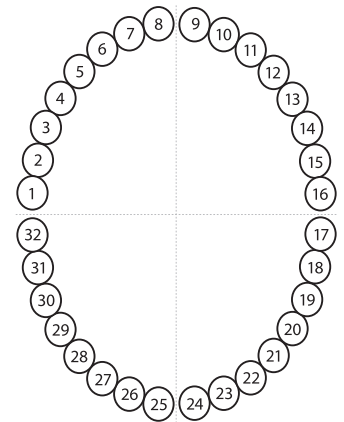
Endo

Oral Surgery

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: _____

Endodontist: Dr. William Posner • Oral Surgeons: Dr. Juan Arroyo, Dr. Nishul Patel
 Periodontist: Dr. Francisco Oliver