



Dental Specialty Center of Miami Beach

PATIENT INFORMATION

Date: ____/____/____

Insurance: _____ Discount plan _____% No Insurance

Account #: _____

Patient Name: _____ Date of Birth: ____/____/____

SSN: _____ - _____ - _____ Phone: (____) _____ - _____

Referred From Office: _____ Phone: (____) _____ - _____

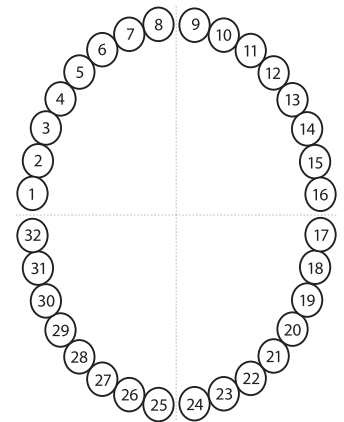
Referring Doctor Name: _____

Refer To: (please circle one)

Endo **Oral Surgery** **Perio** **Prosth**

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 • Periodontist: Dr. Francisco Oliver • Prosthodontist: Dr. Federico Diez

333 ARTHUR GODFREY ROAD • SUITE 818 • MIAMI BEACH, FL 33140 • 305-674-9994 • FAX 305-674-1553