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 **Ortho** **Os** **Pedo** **Perio** **Prostho**

Dental Specialty Center Location: ____

____

____

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: ____