

# Dental Specialty Center

## PATIENT INFORMATION

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

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

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

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

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

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

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

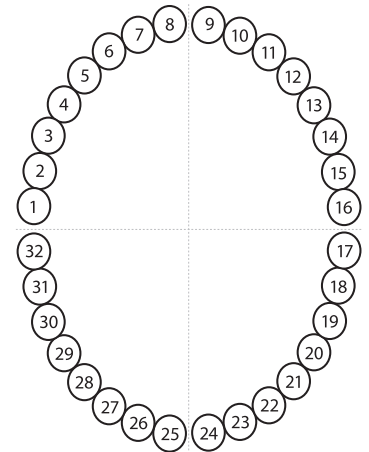
Refer To: (please circle one)

**Endo**
**Ortho**
**Os**
**Pedo**
**Perio**
**Prosth**

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: \_\_\_\_\_