

Dental Specialty Center of Aventura

PATIENT INFORMATION

Date: ___/___/___

Insurance: _____ Discount plan _____% No Insurance

Account #: _____

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

SSN: ___-___-___ Phone: (____) ___-___

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

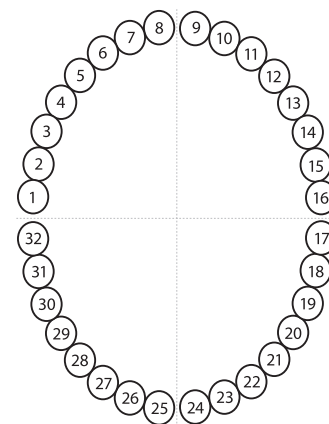
Referring Doctor Name: _____

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: _____

Periodontist: Dr. Steven Berkowitz • Oral Surgeon: Dr. John Pasqual
 Endodontist: Dr. Anas Selman