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: ____

____

____

8 9 10 11 12 13 14 15 16 7 6 5 4 3 2 1

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

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

19086 NE 29TH AVENUE • AVENTURA, FL 33180 • 305-682-9468 • FAX 305-933-4352