Dental Specialty Center
of Cutler Bay

PATIENTINFORMATION

Date: _____/_____/_____

Insurance: _____ ❑ Discount plan _____% ❑ No Insurance

Account #: _____

PatientName: _____ Date of Birth: _____/_____/_____

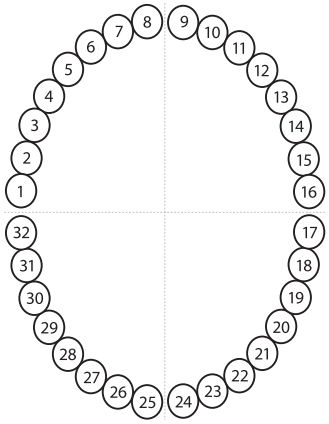
SSN: _____-_____-_____ Phone: (_____) _____-_____

ReferredFromOffice: _____ Phone: (_____) _____-_____

Referring DoctorName: _____

ReferTo: (please circle one)

Endo Oral Surgery Perio Prostho



ServicesNeeded:

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: _____

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