REFERRAL

PATIENT INFORMATION

CHILD NAME: ______________________ DOB: ______________

PARENT/LEGAL GUARDIAN NAME: ______________________

CONTACT NUMBER: ______________________

DENTAL INSURANCE CO.: ______________ ID NUMBER: ______________

POLICY HOLDER NAME: ______________ POLICY HOLDER DOB: ______________

REFERRAL INFORMATION

REFERRING DR. NAME: ______________ OFFICE NAME: ______________

REASON FOR REFERRAL: ______________________

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PLEASE COMPLETE THE FOLLOWING FOR OUR MUTUAL PATIENT:

☐ COMP EXAM ☐ LIMITED EXAM/TX ☐ TAKE X-RAYS ☐ X-RAYS FROM __/__/__ ARE BEING SENT

phone 715.214.1234

fax 715.214.1235

email Referrals@sweettoothkidsdentistry.com

location

311 Financial Way Ste. 200

Wausau, WI 54401

NEED A CORRESPONDENCE LETTER FOR THIS PATIENT?

Please send any requests to Brittany@sweettoothkidsdentistry.com