

PATIENT INFORMATION:

Today's Date _____

First Name _____ Last Name _____ Date of Birth _____

Parent/Guardian Name _____

Contact Telephone _____ Contact E-Mail Address _____

Does the patient require antibiotics prior to dental treatment? Yes No Patient will call for appointment Please call patient
Treatment _____

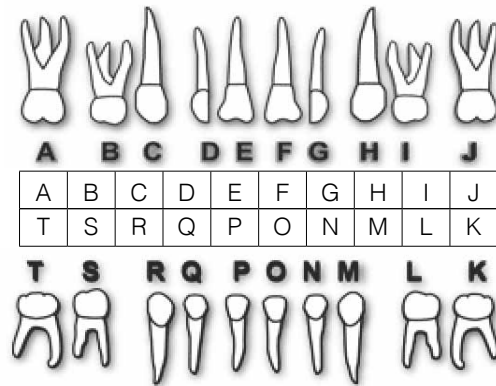
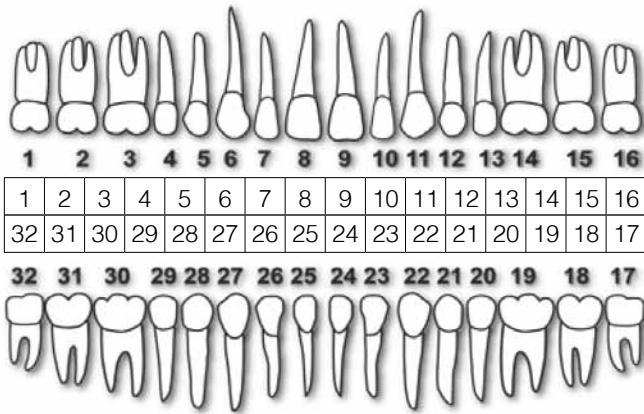
REFERRING DOCTOR'S INFORMATION:

Referred By _____ Telephone _____

E-Mail Address _____

PROCEDURES:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Extraction (see below) | <input type="checkbox"/> Exposure | <input type="checkbox"/> Root Canal |
| <input type="checkbox"/> Alveoplasty | <input type="checkbox"/> Hard Tissue | <input type="checkbox"/> Partials |
| <input type="checkbox"/> Incision & Drainage | <input type="checkbox"/> Infection | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Implant | <input type="checkbox"/> Soft Tissue | <input type="checkbox"/> SRP/Quadrants |
| <input type="checkbox"/> Fillings | <input type="checkbox"/> Bone Graft | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Crowns | <input type="checkbox"/> Buildup | <input type="checkbox"/> Other _____ |



Please Verify Teeth For Extraction and/or implant placement _____

RADIOGRAPHS OR CLINICAL PHOTOS:

- Please Take
 No X-Ray
 Attached with this referral.
 If X-Rays are attached, what date were they taken _____

INSURANCE INFORMATION:

Insurance Company _____ Member ID _____

Group # _____

CASE NOTES:

Please submit completed form and x-rays to office@woodlanddb.com

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