SUMAS MOUNTAIN VILLAGE

DENTAL

REFERRAL FOR TREATMENT

Patients Name: _____ **Date of Birth:** _____

Phone Number: _____ **Date Of Referral:** _____

Dental Insurance Information:

Insurance Holder: _____ **DOB:** _____

Employeer: _____ **Carrier:** _____

Group #: _____ **ID #:** _____ **Div #:** _____

Referring Doctor: _____

Referring Office: _____ **Phone Number:** _____

Please check ☑ all that apply:

- ☐ **Please call Patient**
- ☐ **X-ray imaging is sent by (circle one): E-mail / With the patient / In mail**
- ☐ **Dental insurance information is enclosed**

TREATMENT requested:

18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38

55 54 53 52 51	61 62 63 64 65
85 84 83 82 81	71 72 73 74 75

- ☐ **Dental Crowns**
- ☐ **Extractions**
- ☐ **Dental Filings**
- ☐ **Cone Beam CT Sean (10x10 FOV)**
- ☐ **Dental Hygiene**
- ☐ **IV Sedation**
- ☐ **Dental Implants**
- ☐ **Orthodontics (Brace/Invisalign)**
- ☐ **General Check-ups**

Others:

_____

Additional Comments:

_____

_____

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