

THE SMILE CENTER FAMILY DENTISTRY

☆ www.TheSmileCenterUSA.com ☆

DENTAL PATIENT REFERRAL FORM

Las Palmas
O: 210-435-7653 F: 210-435-7722
Military Plaza
O: 210-547-7191 F: 210-319-1391
W.W. White
O: 210-648-7600 F: 210-333-0828
Park North
O: 210-340-0303 F: 210-340-5426
Walzem Plaza
O: 210-599-4444 F: 210-599-1275
Marbach
O: 210-675-8000 F: 210-675-8001

DATE: _____ REFERRING DOCTOR: _____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PRIMARY PHONE: _____ ALTERNATE PHONE: _____

EMAIL ADDRESS: _____

PRIORITY: ROUTINE URGENT EMERGENCY

TOOTH NUMBER(S): _____

REASON FOR REFERRAL: ENDO IMPLANT INVISALIGN AGED OUT OF PEDI. PRACTICE
 3RD MOLAR EXTRACTION VENEERS OTHER: _____
(in most cases)

DOCTOR'S COMMENTS: _____

REFERRING OFFICE WILL PROVIDE:

TREATMENT NOTES/PLAN RADIOGRAPH(S)

REFERRING OFFICE REQUESTS: _____

THE SMILE CENTER ACCEPTS:

Medicaid

TriCare

United Concordia

Delta

CHIP

StarHealth

MetLife

Please call to verify other carriers

The Smile Center appreciates your trust in all our family dentistry professional services and will provide your patients the same level of care and respect that they receive when at your office. Please don't hesitate to contact The Smile Center with any questions about our full-service practice or for more referral information.

REFERRING DOCTOR SIGNATURE _____

OFFICE PHONE _____

Please FAX this form to our office and give the original to the patient for reference.

☆ Making smiles easy!