Village kids DENTISTRY
Knowles, Smith & Associates LLP

Patient Referral Form

Patient Details

First Name _____ Last Name _____

Address _____

Phone (cell) _____ (home)_____ DOB ____/____/_____

Email _____

Insurance Coverage	____ Cash	____ Insurance	____ Medicaid
X-rays Enclosed?	____ Yes	____ No	
Study casts enclosed	____ Yes	____ No	
Photos enclosed/attached	____ Yes	____ No	

Referring Practitioner Details

Practice Name _____ Referring Doctor _____

Address _____

Email _____

Office contact _____ Phone _____

Please Indicate Type of Referral

____ First Dental Visit	____ Decay/Caries	____ Dental Trauma
____ Enamel Defect	____ Frenectomy (Tongue/Lip Tie)	

____ Other: _____

_____

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