



# PRAIRIE

Oral Surgery

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## PATIENT REFERRAL FORM

Patient Name \_\_\_\_\_ Sex:  M  F

Patient Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Phone # \_\_\_\_\_ Patient DOB \_\_\_\_\_

Responsible Party \_\_\_\_\_ DOB \_\_\_\_\_

(if patient is under 18)

Images Included  Date of Image \_\_\_\_\_

Evaluate for:

Extractions \_\_\_\_\_

Dental Implants \_\_\_\_\_ Pathology \_\_\_\_\_

Preprosthetic Surgery \_\_\_\_\_ Facial Pain \_\_\_\_\_

Jaw Surgery \_\_\_\_\_ Cosmetic Surgery \_\_\_\_\_

Other \_\_\_\_\_

Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17



A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Referring Doctor (print name) \_\_\_\_\_

Referring Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

Insurance Co. Name _____	Insurance Co. Name _____
Subscriber Name _____	Subscriber Name _____
Subscriber DOB _____	Subscriber DOB _____
Subscriber ID _____	Subscriber ID _____
Group ID _____	Group ID _____