Cedar Lodge
DENTAL GROUP EST. 1985

Date:_____ Referring Doctor:_____

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ Zip:_____

Responsible Party:_____ Relation to Patient: _____

Email Address:_____

Phone Number :_____ Alternate Phone:_____

Reason for Referral: ☐ Sedation ☐ Treatment **without** Nitrous ☐ Treatment **with** Nitrous

☐ Botox/Fillers ☐ Expansion/Airway Evaluation ☐ Other:_____

Suggested Treatment Plan if Available or Additional Comments: _____

_____

_____

Was treatment attempted in your office already? ☐ Yes ☐ No Has Nitrous been used previously?

Carrier:_____Subscriber:_____

Subscriber DOB:_____ID #:_____

Group Number:_____Group Name:_____
**Note: we do not accept KanCare or Medicare

If the patient has had any x-ray's or a pano recently, please email over to our office at our new email
referrals@cedarlodgedental.com

Referring Doctor's Signature: _____

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