MAHEC
Dental Health Center and Center for Advanced Training
123 Hendersonville Road, Asheville, NC 28803
(828) 252-4290 • Fax (828) 337-5871 • dhcinfo@mahec.net

REFERRAL FORM

Date of Referral _____

Doctor Information

Name of Practice _____
Name of Referring Doctor _____
Office phone number _____ Office Fax number _____
Email _____

Patient Information

Full Name _____
Best Contact phone number _____ Alternate phone number _____
Insurance Type (circle one): Self-pay Commercial Insurance Medicaid #_____
Date of Birth: _____Patient e-mail_____
Parent/Guardian Name and contact number if applicable _____

Appointment needed

- ☐ Tooth to be evaluated #____
- ☐ Emergency treatment requested
- ☐ Please schedule at your convenience
- ☐ Other

X-ray of Tooth

- ☐ Date taken:_____
- ☐ Copy given to patient
- ☐ X-ray e-mailed to dhcinfo@mahec.net on _____
- ☐ Please take new X-ray

Please give brief description of patient's symptoms, history, and <u>any prescribed medications</u> or pain management instructions given.

_____
_____
_____
_____

MAHEC reserves the right not to re-schedule if you fail to show up for your appointment.

Patient Signature: _____