Dental Health Center and Center for Advanced Training
123 Hendersonville Road, Asheville, NC 28803
(828) 252-4290 • Fax (828) 333-5871 • 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.

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

Patient Signature: ____