Brian A. Houston, DDS, A.P.C.
Sukhmani Singh, DDS, A.P.C.

PROSTHODONTISTS

(T) 707.745.8002
(F) 707.745.6347
142 East D Street
Benicia, CA 94510
www.carquinezdental.com
frontdesk@carquinezdental.com

Patient Name: _____ **DOB:** _____

Patient Phone: (___) _____ **Patient E-mail:** _____

Reason for Referral: _____

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PLEASE CIRCLE TOOTH OR AREA TO BE EVALUATED/TREATED

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

☐ PATIENT WILL CALL FOR APPOINTMENT
☐ CONTACT PATIENT TO MAKE APPOINTMENT

RADIOGRAPHS

☐ EMAILED ☐ ENCLOSED ☐ PLEASE TAKE

PRIMARY INSURANCE

DENTAL INSURANCE CO: _____
INSURED'S NAME: _____
DOB: _____
MEMBER ID/SSN: _____
INSURANCE PHONE: _____

SECONDARY INSURANCE

DENTAL INSURANCE CO: _____
INSURED'S NAME: _____
DOB: _____
MEMBER ID/SSN: _____
INSURANCE PHONE: _____

REFERRING DR.: _____
ADDRESS: _____
DATE: _____ **PHONE:** (_____) _____

◈ **PLEASE FAX, MAIL, OR EMAIL THIS FORM TO OUR OFFICE**

PLEASE HAVE THE FOLLOWING ITEMS WHEN CALLING OUR OFFICE:

1) NAME AND DATE OF BIRTH OF INSURANCE SUBSCRIBER
2) DENTAL INSURANCE CARD/INFO
3) THIS REFERRAL ISSUED BY YOUR DENTIST