Request For Dental Care Form

Date:____________________

Patient Information

Last Name:________________________________ First Name:______________________________

Date of Birth: ____________________ Gender: MALE ◯ FEMALE ◯ PREFER NOT TO SAY ◯

Facility Name: ____ Room No. ____________

Insurance: YES ◯ NO ◯

If yes, insurance provider:______________ Insurance plan #: __________ Insurance membership #: __________

Power of Attorney for Care

Last Name:________________________________ First Name:______________________________

Address: ________________________________ City: ______________ Postal code: ____________

House/Apt # Street name

Email: ____

Phone: (Home)____________________ (Cell) ____________________

Preferred mode of contact: PHONE ◯ EMAIL ◯ Relationship to Resident:____________________

Power of Attorney for Finance

Same as above: ◯

Last Name:________________________________ First Name:______________________________

Address: ________________________________ City: ______________ Postal code: ____________

House/Apt # Street name

Email: ____

Phone: (Home)____________________ (Cell) ____________________

Preferred mode of contact: PHONE ◯ EMAIL ◯ Relationship to Resident:____________________

Provider type needed: DENTIST ◯ HYGIENIST ◯ DENTURIST ◯ Medical Record attached: YES/No

Reason for service: