VERMONT DENTAL MEDICINE

Vermont Orofacial Pain Associates

Powered By Vermont Dental Medicine

40 A Timber Lane, South Burlington, Vermont 05403

New Patient Referral Form

Patient Name (required): _____ DOB (required): ____/_____/_____

Gender (required): _____ Email Address:_____

Phone (required):_____ Address: _____

Reason for the referral:_____

Referring Provider Information

Name of the provider (First name and last name required): _____

NPI (required): _____

Name of the practice or organization:_____

Phone number: _____ Email address: _____

Office address: _____

Is this provider contracted with (required) Medicare Yes___ No___ Vermont Medicaid Yes___ No___

Referral Information

Date of the referral: _____

Reason for the referral/Chief Complaint:

_____

_____

_____

_____

Enclosed files:

Panoramic X-ray: ____ FMX: ____ CT-Scan: ____ MRI: ____ Photographs: ____ Oral Scans: ____

Additional Comments:

_____

Referring provider signature

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