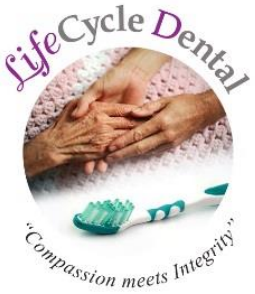

LIFECYCLE DENTAL REFERRAL FORM

Date of Referral _____
Facility Name _____
Patient's Name _____

Does the patient have:

A. Any Natural Teeth	Yes ☐	No ☐
B. Dentures or Partial Dentures	Yes ☐	No ☐
C. Pain	Yes ☐	No ☐

Specific Problem(s):

_____
_____
_____

BUSINESS OFFICE INFORMATION

*** This section is **required** and needs to be completed by your book keeper. We can **not** see patient until this portion is complete.

Is this patient:

Private Pay?	Yes ☐	No ☐
Applied Income?	Yes ☐	No ☐

If Yes, what is the amount? _____
What is patient's Medicaid number? _____
Who is this resident's rep payee? _____
Is this resident current on rent? Yes ☐ No ☐
If not current, what months are late? _____

Please Fax Form To: 817-439-8774

LifeCycle Dental Resources ®
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