DR. STUART DEXTER
PROSTHODONTIST

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DexterDentalFrontDesk@gmail.com

W. Stuart Dexter, DDS *Maxillofacial Prosthodontist*

PATIENT'S NAME _____

PATIENT'S PHONE _____

DOB _____ / _____ / _____

PRE-MED REQUIRED ☐ Yes ☐ No

TAKING BLOOD THINNERS ☐ Yes ☐ No

TAKING BISPHOSPHONATES ☐ Yes ☐ No

MEDICAL HISTORY CONCERNS _____

CHIEF DENTAL CONCERNS _____

REFERRED BY DR. _____

TREATEMENT REQUESTED _____

RADIOGRAPHS

- ☐ Take
- ☐ Emailed to dexterdentalfrontdesk@gmail.com

FOLLOW UP

- ☐ Once treatment is completed, the patient will return to their referring dentist for recall (routine care)
- ☐ Please have recall appointments alternating between offices for maintenance

Along with this referral sheet, please bring the following to your first appointment:
- A list of medications you are currently taking
- Any dental prosthesis which you are wearing or having trouble wearing

Insurance Information We are a fee for service office, which means that we do not participate with insurance and are considered out ouf network. Fees for services provided are due at the time of service. We will however, submit your completed services on a dental claim to your insurance company for reimbursement directly to you. Note: We cannot guarantee payment from your insurance nor can we guarantee that payment to be the full amount from services incurred.