APPLE TREE DENTAL
Access • Compassion • Excellence

Mounds View Center for Dental Health
2442 Mounds View Blvd
Mounds View, MN 55112
phone: 763-316-5400
fax: 763-780-9005
www.appletreedental.org

Referral Form

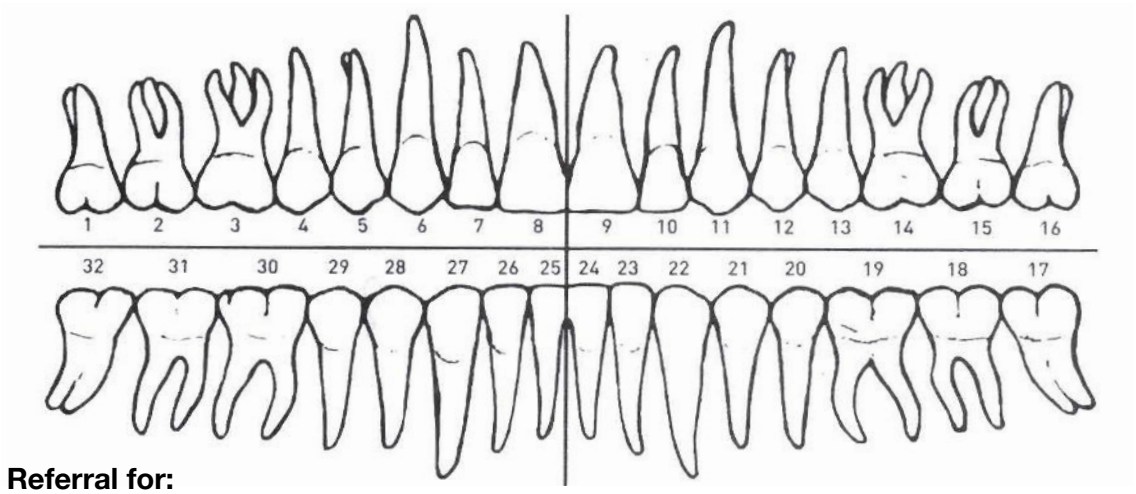
Patient Name: _____

Patient Phone: _____ Date of Birth: _____

Radiograph Information: ☐ will e-mail to: referrals@appletreedental.org ☐ mailed ☐ none available

Tooth/Teeth #: _____

***Please circle/draw on tooth chart below as indicated.**



Referral for:

☐ IV Sedation
☐ Extraction(s)
☐ Implant/Bone Graft
☐ Alveoloplasty
☐ Frenulectomy/Gingivectomy
☐ 3D Cone Beam Imaging (CBCT)
☐ Consultation/Second Opinion
☐ Special Needs Dental Care
☐ General Care
☐ Transferring Care to Apple Tree Dental
☐ Other, please specify: _____

Check all that apply:

☐ Patient in pain
☐ Dental anxiety
☐ Unable to anesthetize adequately
☐ Patient requests/needs sedation

Additional Information: _____

Name of Clinic: _____ Date of Referral: _____

Address: _____ Phone: _____

e-mail: _____ Fax: _____

Referring Provider: _____