APPLE TREE DENTAL
Access • Compassion • Excellence

Mounds View Center
MV@appletreedental.org
763.316.5400

Referral Form

Patient Name: _____

Patient Phone: _____ Date of Birth: _____

Responsible Party Name: _____ ☐ N/A

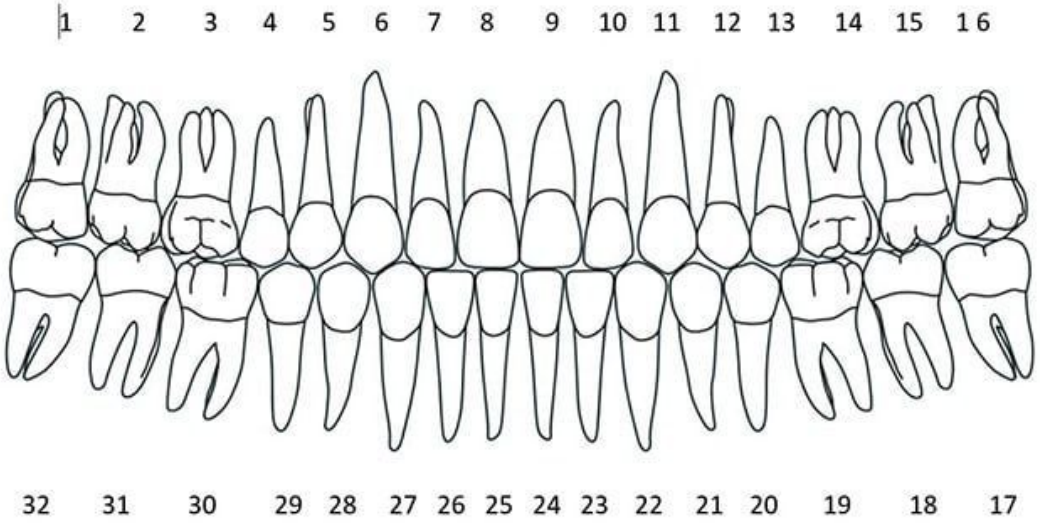
Responsible Party Phone and E-Mail: _____ ☐ N/A

Radiograph Information: ☐ Will email MV@appletreedental.org ☐ Will mail ☐ None Available

Radiograph Type: ☐ PA ☐ BW ☐ Pano Date(s) Taken: _____

Tooth/Teeth #: _____

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



Referral for:

☐ Extraction(s)
☐ Implant
☐ Bone Graft
☐ Alveoloplasty/Tori Removal
☐ Other, please specify: _____
☐ Consultation
☐ Frenulectomy/Gingivectomy

Check all that apply:

☐ Patient in pain ☐ Acute infection/swelling ☐ Dental anxiety

Name of Clinic: _____ Date of Referral: _____

Address: _____ Phone: _____

E-mail: _____

Referring Clinician: _____