PL DENTAL
GENERAL DENTIST

Patient: _____

Date: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

REFERRAL INFORMATION

Referring to

◯ Dr. Phong Ly DDS
12628 Fremont Ave
Zimmerman MN 55398
(833) 217- 5959

◯ Dr. Phong Ly DDS
9920 Foley Blvd NW, Ste 110
Coon Rapids MN 55433
(763) 317 -1166

INSURANCE INFORMATION

◯ No Dental Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Proposed Tx _____

Patient was referred for _____

Comments _____

_____ _____

Provider Signature Date