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HEALTH CARE PROVIDERS

PATIENT NAME: _____ **DATE**: _____

Referring Practitioner: _____
Type of Doctor: _____
Address: _____
_____
Phone / Fax #: _____

Please list the other physicians, dentists and / or health care providers that are involved in your treatment. Consultation letters will be mailed to all providers that participate in your health care unless you specify otherwise.

Primary Dentist: _____
Type of Doctor: _____
Address: _____
_____
Phone / Fax #: _____

Primary Physician: _____
Type of Doctor: _____
Address: _____
_____
Phone / Fax #: _____

Dental Specialist: _____
Type of Doctor: _____
Address: _____
_____
Phone / Fax #: _____

Medical Specialist: _____
Type of Doctor: _____
Address: _____
_____
Phone / Fax #: _____

_____
SIGNATURE