JOEL M LAUDENBACH DMD | DIPLOMATE, AMERICAN BOARD OF ORAL MEDICINE
ORAL DIAGNOSIS CONSULTATION & MANAGEMENT

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 may be mailed to all providers listed on this form 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 #: _____

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