

# Richard Polson, R.Ph., D.D.S.

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## Referral Form

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient DOB \_\_\_\_\_

Patient Phone # \_\_\_\_\_

Referring Provider \_\_\_\_\_

Provider Phone # \_\_\_\_\_

Provider Fax # \_\_\_\_\_

Provider Email \_\_\_\_\_

Diagnosis / Complaint or Your Findings \_\_\_\_\_

\_\_\_\_\_

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If available, please fax a copy of the patient's insurance information to (817)571-9571. If you have a current panorex x-ray (less than six months old), please mail to our office or email to [craniopa@swbell.net](mailto:craniopa@swbell.net).

**Thank you for letting us help you care for your patients.**