Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 650-5150
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909
Email: Oral.Surgery@hitchcock.org

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

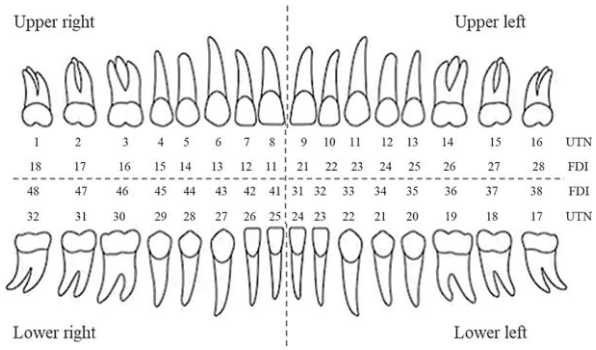
Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Oral and Maxillofacial Surgery

Please indicate the diagnosis for which you are referring this patient:

525.9 (ICD-9-CM) - K08.9 (ICD-10-CM) - Extraction of tooth needed. Please mark teeth to be removed in the diagram:



Other (Please Specify) _____

_____

_____

Diagnosis: _____

_____

_____

_____

_____

ICD Code: _____