



REFERRAL FORM

Lewis D. Gilbert, DDS
Managing Partner

Email to info@smilewv.com
or Fax to Your Preferred Office

Krstal K. Thompson, DDS
Associate

PATIENT

Name: _____ DOB: ____/____/____

Address: _____ Home Phone: _____

Alt. Phone: _____ Email: _____

Guardian (if under 18): _____ Relationship: _____ N/A

Health Issues and/or Medications: _____

PAYMENT PREFERENCE Insurance: _____ Private Pay Other: _____

PREFERRED OFFICE

- Beckley Princeton
 Summersville

PANOREX

- Patient Bringing* Emailed/Mailed*
 New Pano Needed

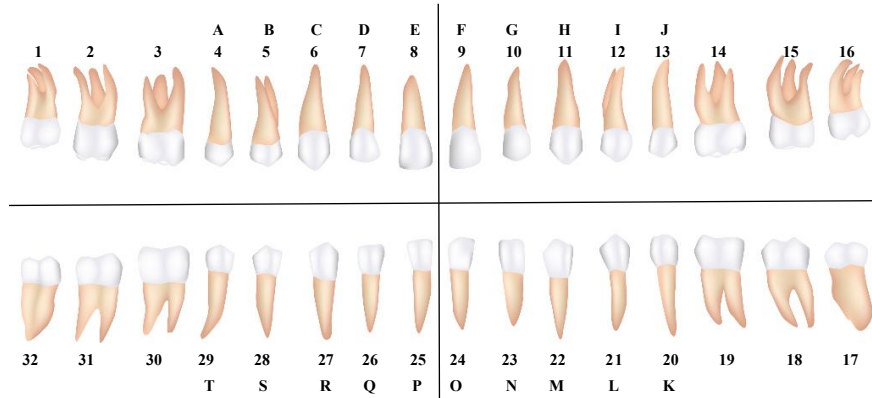
**Please note pano must be less than one (1) year old.*

CONSULTATION/PROCEDURE

- Dental Implant(s) Dento-Alveolar
 Extraction(s) Expose/Ligate
 Wisdom Teeth Facial Trauma
 Pathology Frenectomy
 Other/Notes: _____

TREATMENT AREAS

Please mark each area to be evaluated.



REFERRING OFFICE

Referring Physician: _____ Date: ____/____/____

Phone: _____ Fax: _____ Email: _____

433 Carriage Drive
Beckley, WV 25801
P: (304) 256-3777
F: (304) 256-3779

807 Broad Street
Summersville, WV 26651
P: (304) 872-0300
F: (304) 872-5999

220 Locust Street
Princeton, WV 24740
P: (304) 425-8220
F: (304) 425-8238