REFERRAL FORM

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

Lewis D. Gilbert, DDS
Managing Partner

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: ______________________________

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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:** ______________________________

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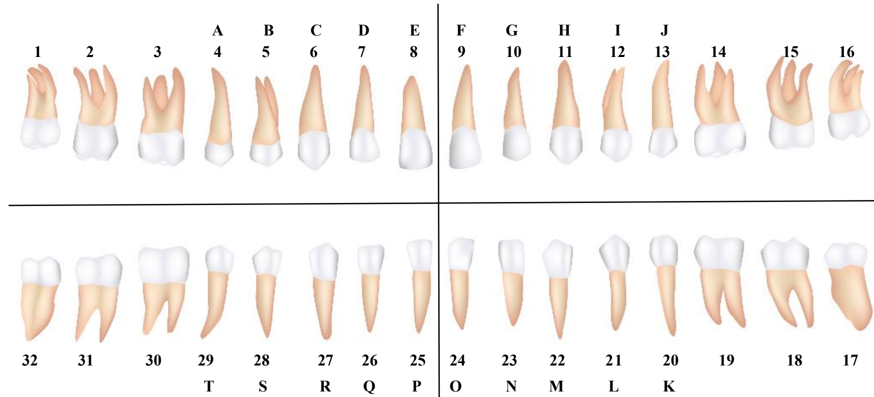
TREATMENT AREAS

Please mark each area to be evaluated.



REFERRING OFFICE

Referring Physician: ______________________________ **Date:** ______/______/______

Phone: ______________ **Fax:** ______________ **Email:** ______________________