Please Fax to (760) 396-5723

Indio Surgery Center Referral

46-900 Monroe St., Ste. B-201, Indio, Ca 92201
Phone (760) 396-5733

Referring Doctor______________________________ Date________________

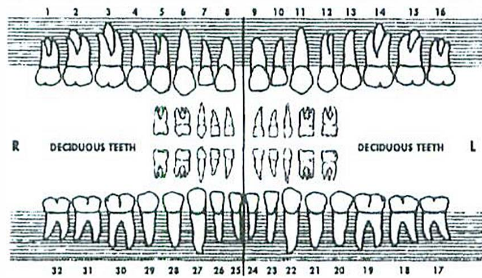
Patient's Name______________________________ DOB________________

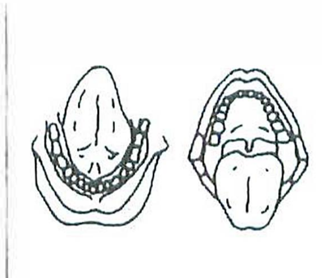
Address____

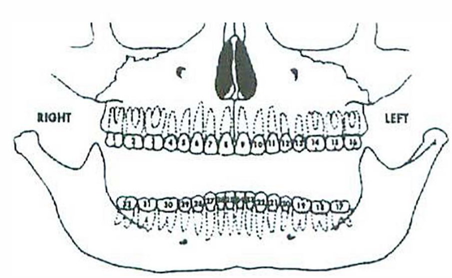
Phone________________________ Cell________________________

Insurance Information____

PLEASE MARK TEETH FOR TREATMENT AND/OR AREA(S) TO BE EXAMINED ON DIAGRAMS BELOW:







Other Procedure

(Describe)____

____

Comments or Special

Instructions:____

____

Referring Doctor's Signature____________________________ Date________________

Bring any information with you regarding your treatment, such as: referral, x-ray, medical history including medications, allergies, etc. If you are under 18, you must bring a parent with you.

www.indiosurgerycenter.com