# Patient Referral Form

Williams Oral & Maxillofacial Surgery

Please thoroughly complete the following form and submit to our office by e-mailing referrals@williamsoms.com or faxing (605) 348-1626. Patients will be contacted once their referral has been processed. Please allow up to 3 business days for processing.

Patient's DOB _____ ☐ Patient is a minor Referral Date _____

Patient's Full Name _____

Patient's Mailing Address _____

City _____ State _____ Zip _____

Patient's Phone (Home) _____ Patient's Phone (Cell) _____

***Parent/Guardian's information must be provided for any patient that is under 18 years of age.***

Parent/Guardian's Full Name _____

Parent/Guardian's Address _____

City _____ State _____ Zip _____

Parent/Guardian's DOB _____ Parent/Guardian's Phone _____

**TREATMENT REQUESTED** ***Please specify all tooth numbers (including wisdom teeth) with treatment requested.***

_____

_____

_____

**TAKE:** ☐ Pano ☐ CBCT **SENT:** ☐ Pano. date _____ ☐ PA(s) date _____ ☐ CBCT date _____

Health Concerns / Allergies / Meds: _____

_____

☐ Patient is self-pay ☐ Patient has SD Medicaid # _____ ☐ Patient has dental insurance

*SD Medicaid referrals are subject to pre-authorization prior to scheduling. Please note that medical insurances do not provide coverage for tooth extractions.*

Insurance Company _____ ID # _____ Group # _____

Policy Holder _____ DOB _____ Relationship _____

**REQUIREMENT for SD Medicaid Wisdom Teeth Referrals**: A Third Molar Referral Form and a panoramic x-ray (taken within the last year) must be included with this patient referral form. Please visit our website at williamsoms.com to download the Third Molar Referral Form.

Referring Doctor _____ Practice _____ Phone _____

*This referral is void if the referring doctor's information is not provided above.*

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