Patient Referral Form

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 ______________________________ ☐ Male ☐ Female ☐ Other

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 Mailing Address ______________________________

City ______________________ State ______ Zip ______________

Parent/Guardian's DOB ______________ Parent/Guardian's Phone ______________________

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

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

Health Concerns / Allergies / Medications: ______________________________

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☐ Patient is self-pay ☐ Patient has SD Medicaid – ID # ______________ ☐ 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 ______________________________ Phone ______________________

This referral is void if the referring doctor's name and phone number are not provided above.

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