Pi Dental Center
467 Pennsylvania Avenue, Suite 201
Fort Washington, PA 19034
(215) 646-6334 FAX (215) 643-1149

NEW PATIENT REFERRAL FORM

Referred to: ☐ **Dr. Glenn Wolfinger** ☐ **Dr. Thomas Balshi** ☐ **First Available**

Date: _____ **Referred By:** _____

Referring Dr. Office Phone: _____ **Referring Dr. Email:** _____

Patient Name: _____

Patient Address: _____

_____ **(Email)** _____

Patient Phone: (Home) _____ **(Work)** _____ **(Cell)** _____

Referred for:

	UPPER	LOWER	TOOTH NUMBERS
☐ Complete Dentures	☐	☐	
☐ Partial Dentures	☐	☐	
☐ Dental Implant Treatment	☐	☐	
☐ Crowns	☐	☐	

Other: _____

_____

Medical Alerts: _____

Radiographs: ☐ **Please take X-Ray** ☐ **FMX being sent** ☐ **Panoramic Radiograph Available** ☐ **CT Scan Available**

Appointment Status:
☐ **Our office will call patient to coordinate appointment.**
☐ **The patient will call your office to schedule appointment.**
☐ **Please call our office before seeing the patient.**

Please fax this completed form to (215) 643-1149 or email to piteam@pidentalcenter.com
The patient will be contacted immediately for appropriate evaluations.