



**Dr. Tuong Ta**

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Date: \_\_\_\_\_

Referring Patient: \_\_\_\_\_ DOB \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

**Insurance Information:**

Insurance Company : \_\_\_\_\_ Employer : \_\_\_\_\_

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Member ID# : \_\_\_\_\_

Insurance Phone # : \_\_\_\_\_ Group Number: \_\_\_\_\_

Please check if relevant:

- Radiographs were obtained (please include via Email)
- Failed oral sedation treatment
- Medically compromised (please indicate condition: \_\_\_\_\_)
- Other: \_\_\_\_\_
- Please Call Me Regarding This Patient