DEVOTED DENTAL

Provider Referral Form

Refer a patient to Devoted Dental Group — we'll take great care of them

Referring Provider Information

Prefix

Full Name *

Office Name *

Phone *

Email *

Office Address *

City

State

ZIP

Patient Information

Prefix

Patient Full Name *

Date of Birth (MM/DD/YYYY) *

Patient Phone

Patient Email

Insurance

Referral Details

Reason for Referral *

Tooth Number(s)

Additional Clinical Notes

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Page 2 — Preferred Location & Submission Instructions

Preferred Devoted Dental Location

Check the office closest to your patient. All 5 locations accept Medicaid, Medicare, and 50+ PPO plans.

☐ **Chesterfield**
33497 23 Mile Rd #140, New Baltimore, MI 48047
(586) 325-3000 | contactcf@devoteddentalgroup.com

☐ **Highland**
2287 S Milford Rd, Highland Charter Twp, MI 48357
(248) 717-2911 | contact@devoteddentalgroup.com

☐ **Livonia**
30499 Plymouth Rd, Livonia, MI 48150
(734) 444-8888 | contactliv@devoteddentalgroup.com

☐ **Warren**
29856 Schoenherr Rd, Warren, MI 48088
(586) 250-5000 | contactwar@devoteddentalgroup.com

☐ **Wyandotte**
1307 Ford Ave, Wyandotte, MI 48192
(734) 288-9999 | contactw@devoteddentalgroup.com

X-Rays & Imaging

This form doesn't attach files. Please send X-rays or CBCT imaging separately, referencing the patient's name, to the email address for your selected office above.

How to Submit This Form

1. Fill out this form on-screen (in Adobe Acrobat or a PDF reader that supports form fields), or print and complete by hand.
2. Save or scan the completed form.
3. Email it to your selected office above, or call the office directly to coordinate a secure fax.

Referring Provider Signature _____ Signature

Date _____ Date