Eagan Valley Dental Center

Erik Solberg, DDS

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Date of Referral: _____

Patient Name:_____

DOB: _____ Patient Phone Number:_____

☐ Please Call Patient to Set Up Appt. ☐ Patient Will Call to Set up Appt.

☐ Appointment Set Already on: _____

Referring Doctor Name:_____

Preferred Email or Phone #:_____

Radiographs:
☐ Please take own radiographs
☐ Radiographs will be emailed or with patient

We will complete only the care you request of us and ensure the patient returns to your practice for all of their other dental care. We truly appreciate the trust you place in us to help care for your patient.

Reason for Referral (Check all that Apply)

Tooth Sites: _____

☐ Extraction(s) with Bone Graft as needed
☐ Implant Placement Only
☐ Final Abutment Placement
☐ Sinus Lift or Ridge Augmentation
☐ Wisdom Tooth Extraction
☐ Crown Lengthening
☐ CBCT Scan Only
☐ Pre-Prosthetic Surgery

Comments:_____

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Dr. Solberg Limits his Practice to Implant, Surgical and Sedation Care