MOXIE
DENTAL
DR. KYLE LISENBY

Request for Care and/or IV Sedation

Patient Information

Patient Name: _____

DOB: _____/_____/_____ Phone: _____/_____-_____

Please evaluate for treatment (check all that apply)

- Removal of _____
- Removal of All Remaining Wisdom Teeth
- Bone Grafting _____
- Placement/Eval of Implants _____
- General Dentistry_____
- IV Conscious Sedation

Helpful Information for the patient…

1) Dental Practice to Contact:
   Moxie Dental **records@moxiedentalmo.com**
   3621 Discovery Parkway, Ste 101 **573.222.0604**
   Columbia, MO 65201
2) We will evaluate your concern and provide a treatment cost estimate at your 1st visit
3) We will complete and mail your claim form on your behalf
4) We process most insurance plans & offer **in-network preferred provider savings of 30-40% for:**
   Delta Dental

Referring Clinician

Doctor Name: _____ Date: _____/_____/_____

Doctor Signature: ____