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
   3621 Discovery Parkway, Ste 101
   Columbia, MO 65201

   records@moxiedentalmo.com
   573.222.0604

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: ____