DeKalb Medical
Physicians Group

Stephanie Wetzel, DDS

Physician Referral Form

Date: _____

Patient Name: _____

Phone: _____ Date of Birth: _____

Location of Lesion:_____

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Additional Comments:_____

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Physician Name:_____Date:_____Time:_____

Address: _____

Phone: _____ Fax: _____

Once complete, please fax to: (404) 974.2699

With You all the way.™