

**Graduate Periodontics Program**

1201 N. Stonewall Ave, Room 253

Oklahoma City, OK 73117

phone: 405-271-7020 | fax: 405-271-3794

**Periodontal Referral Form**

Date Referred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Please send copies of insurance card (front and back) and demographic sheet to** [**gradperio@ouhsc.edu\*\***](mailto:gradperio@ouhsc.edu**)

**A close-up of a logo

Description automatically generatedChart

Description automatically generated with medium confidenceA picture containing logo

Description automatically generatedText

Description automatically generated with low confidenceWe are contracted with the below insurance companies. In addition, we gladly file insurance for patients outside our network, but payment will be expected at the time of serivce.**

**Reason for Referral:**

Periodontal Evaluation Periodontal Surgery Soft tissue grafting

Dental Implant Placement Extraction Ridge Augmentation

Sinus Augmentation Peri-Implantitis Pathology/Biopsy

Crown Lengthening Sedation Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tooth Number(s):**

|  |  |
| --- | --- |
| 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 |
| 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17 |

**Please email radiographs to** [**gradperio@ouhsc.edu**](mailto:gradperio@ouhsc.edu)

**Periodontal Treatment Completed in Your Office:**

Prophylaxis SR/P  Periodontal Maintenance Therapy

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments:**