



COLLEGE OF DENTISTRY

The UNIVERSITY of OKLAHOMA HEALTH SCIENCES CENTER

Oral & Maxillofacial Pathology

OU Dentistry New Patient Referral Form

Dr. Ronald Faram & Dr. Kathleen Higgins

405-271-5714

Date: _____

Patient Information

Patient's First Name: _____ Last Name: _____

DOB: _____ Social Security #: _____ Gender: Female Male

Address: _____

Daytime Phone: (____) _____

Diagnosis/Reason for referral:

Medical Insurance Information

Health Plan: _____ Phone #: _____

Authorization # if HMO or Tricare Prime: _____

Group#: _____ Member ID: _____

Referring DDS/MD Contact Information

Referring Dr.: _____

NPI: _____

Phone (____) _____ Fax: (____) _____

Referring Office Location: _____

FAX COMPLETED FORM TO: 405-271-2405

or

EMAIL TO: OUDFRONTDESK@OUHSC.EDU

Please note: Our doctors are not currently performing biopsy procedures. This referral is specifically for oral medicine-related concerns only. If a biopsy is indicated please refer to OU OMFS @ (405) 271-4079. New patients in need of TMD evaluations will be referred to Dr. Joe Franco