

**DEPARTMENT OF ORAL IMPLANTOLOGY**

**PHONE**: (405) 271-3956

**FAX**: (405) 271-3966

**EMAIL**: cod-oralimplantology@ouhsc.edu

**Private Dentist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fax Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s DOB:** \_\_\_\_\_\_\_\_\_

**Patient’s Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s last exam:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s last cleaning:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s current periodontal status**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is patient’s treatment**: \_\_\_\_\_\_ **complete** \_\_\_\_\_\_**in progress**

**Implant consult area:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Referring Dentist's Signature Date**

**My signature verifies that this patient is currently receiving comprehensive treatment in my practice and that I will provide the recommended follow-up care indicated**.

*\*I understand and agree that the College of Dentistry’s faculty may decline the referral based on the treatment complexity.*

*\* Please be aware that if implants are placed here, they will be restored here.*

*FEES (as of Sep. 2024) Consult-$38.00 PA-$16.00 Pano-$54.00 CT-scan- $243.00*