COLLEGE OF DENTISTRY

The UNIVERSITY *of* OKLAHOMA HEALTH SCIENCES CENTER

Oral & Maxillofacial Pathology
Patient Referral Form
Dr. Ronald Faram & Dr. Kathleen Higgins

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: (_____)___________________

Office Name/Location: ____

FAX COMPLETED FORM TO: 405-271-3385

or

EMAIL TO: ORAL-PATHOLOGY@OUHSC.EDU

Please note: Our doctors are not currently performing biopsy procedures. This referral is specifically for oral medicine-related & TMJ concerns only. If a biopsy is indicated please refer to OU OMFS @ (405)271-4079