COLLEGE OF DENTISTRY
the UNIVERSITY *of* OKLAHOMA HEALTH SCIENCES CENTER

OU Dentistry
FACULTY PRACTICE

Patient Referral Form

Date: _____ Referred to: _____

Patient Information

Patient's First Name: _____ Last Name: _____
DOB: _____ Social Security #: _____ Gender: ☐ Female ☐ Male
Address: _____
_____
Daytime Phone: (_____) _____

Diagnosis/Reason for referral:

Insurance Information

Health Plan: _____ Phone #: _____
Authorization # if HMO or Tricare Prime: _____ Group#: _____
Member ID: _____

Secondary Insurance, if any other Dental Insurance
Health Plan: _____ Phone #: _____
Group#: _____ Member ID: _____

Referring DDS/MD Contact Information

Referring Dr.: _____
Phone (_____) _____ Fax: (_____)_____
Office Name/Location: _____

FAX COMPLETED FORM TO: 405-271-3385

Submit Form