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**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**)

**We 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.**

**Text

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**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:**