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: ____
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____
____

Insurance Information

Health Plan ___________________________________ Phone # _______________
Authorization # if HMO or Tricare Prime ___________________________________
Group # ____
Member ID ____

Secondary Insurance, if any of 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