**A picture containing text, font, logo, symbol

Description automatically generated**

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 June. 2023) Consult-$38.00 PA-$16.00 Pano-$54.00

CT-scan- $243.00