College of Dentistry

ADVANCED EDUCATION IN GENERAL DENTISTRY

AEGD Referral Form

PLEASE COMPLETE ALL INFORMATION

Patient Name: _____ DOB: _____Social Security #: _____

Today's Date: _____ Parent Name (if patient is a minor):_____

Patient Address: _____ City_____ State_____ Zip_____

Phone Number: _____ Home Cell Work (circle one)

Is the patient listed above a current established patient in your practice? *Yes Or No* (Circle one)

Referring Entity:

Referring Dentist Name: _____

Referring Office Address: _____City_____ State_____ Zip_____

Office Phone: _____ Email:_____

Reason for Referral: (Please Circle All Applicable)

1. Referring entity does not provide this type of treatment.
2. Patient financial considerations.
3. Other reason: _____

Treatment Requested: Tooth #_____☐Endo Tooth #_____ ☐Crown

Tooth #_____ ☐Extraction _____☐Other

Digital image must be e-mail securely with form to *AEGD-Clinic@ouhsc.edu*
Fax (405)271-3851, or mail this form with x-rays to:
AEGD - OU College of Dentistry - 1201 N Stonewall Ave Suite 261 Oklahoma City, OK 73117

Date of Patient's Last Visit and Tx Performed: _____

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 faculty may decline the referral based on treatment complexity or recommend that the patient be screened and accepted for comprehensive care as a patient at the College of Dentistry in order to complete the treatment requested if it is in the patient's best interest to do so.

Referring Dentist's Signature: _____

OU College of Dentistry: 1201 N Stonewall Ave., Suite 261,Oklahoma City, OK 73117
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