Referral Date: ________________

Patient Information:

Patient’s Name: ___________________________________________ DOB: ______ Gender: ___
Home Address: ________________________________________________________________________
City, State, Zip: _______________________________________________________________________
Phone: ___________________ Email: ________________________
Insurance Plan/Provider: ________________________________________________________________
How long has the patient been with your practice? __________________________________________

Referring Practice/Provider:

Practice Name: _______________________________________________________________________
Provider/Doctor Name: __________________________________________________________________
Phone: ___________________ Email: ________________________

Reason(s) for referral (check all that apply):
☐ Oral lesions
☐ Intraoral / Extra oral Swelling
☐ TMJ joint/muscle issues
☐ Clenching or grinding / bruxism
☐ Intraoral pain
☐ Headaches

Please provide a brief description or any additional comments to help us better serve you
__________________________________________________________

This form is available online at dentistry.uic.edu/patients/resources
Please mark in the diagrams below the lesion/pain area, as appropriate:

CONSULTANT’S REPORT – PLEASE PRINT

Date Answered:

Recommendations:

Name:

Signature:

Please bring this form along with all necessary medical reports, records, imaging, and biopsy reports with you to your appointment or fax to us at 312-355-1229.