ORAL AND MAXILLOFACIAL SURGERY COLLEGE OF DENTISTRY

Changing the Future of Oral Health

UIC COLLEGE OF DENTISTRY PATIENT REFERRAL
DEPARTMENT OF ORAL & MAXILLOFACIAL SURGERY ROOM 110
801 S PAULINA ST CHICAGO, IL 60612

Please provide all of the information below and email this form to:

oralsurgery@uic.edu

Date of Referral: _____

Referring Practice / Doctor Name: _____

Phone: _____ Email: _____

Patient's Name: _____ DOB: _____ Gender: ____

Parent/Guardian (if patient is minor): _____

Home Address: _____ City, State, ZIP: _____

Phone: _____ Email: _____

Insurance ID# / Plan: _____

Reason(s) for referral (check all that apply)

Dentoalveolar surgery:

☐ Extraction teeth #s: _____ ☐ Alveoplasty: _____

☐ Incision and Drainage: _____ ☐ Apicoectomy: _____

☐ Biopsy: _____ ☐ Expose and Bond: _____

☐ Frenectomy:_____ ☐ Dentoalveolar trauma:_____

Dental Implants #:_____ Pathology/Biopsy:_____

Orthognathic Evaluation:_____

TMJ Evaluation:_____

Cosmetic Facial Surgery:_____

Are Radiographs Available: ☐ Attached / Will Mail ☐ Not Available

Medical History: ☐ Negative ☐ Significant: _____

Special Needs: _____

Anesthesia Recommendations:

☐ Local anesthesia ☐ IV Sedation ☐ General anesthesia, operating room

Other Comments: _____

_____

_____

Please mark teeth to be extracted on diagram: