PERIODONTICS
COLLEGE
OF DENTISTRY

Changing the Future of Oral Health

UIC COLLEGE OF DENTISTRY PATIENT REFERRAL

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

DEPARTMENT OF PERIODONTICS ROOM 331
801 S PAULINA ST CHICAGO, IL 60612
312-996-7374 (Office) | 312-996-8878 (Fax)

Date of Referral: _____

Referring Practice/Provider:

Practice: _____ Doctor: _____

Phone: _____ Email: _____

Patient Information:

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

Parent/Guardian (if patient is minor): _____

Home Address: _____

City, State, ZIP: _____

Phone: _____ Email: _____

Insurance Plan/Provider: _____

How long has the patient been with your practice? _____

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

☐ Implants
☐ Periodontitis
☐ Vertical Defects (GTR)
☐ Ridge Augmentation (GBR)
☐ Sinus Lift (Internal/External)
☐ Orthodontic Exposure
☐ Extraction and Socket Preservation
☐ Gingivectomy
☐ Esthetic Crown Lengthening
☐ Implant Failure Management
☐ Crown Lengthening
☐ Soft Tissue Grafting (Root covering, Post Ortho)

Tooth/Region Number _____

Please indicate and include any of the following as available:
☐ Photos
☐ Panoramic X-rays
☐ Full mouth series
☐ CT Scan

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