PEDIATRIC DENTISTRY COLLEGE OF DENTISTRY

Changing the Future of Oral Health

UIC COLLEGE OF DENTISTRY PATIENT REFERRAL

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

UIC Department of Pediatric Dentistry
Fax: (312) 413-3400 | Phone: (312) 996-7532
Email: dentpediatrics@uic.edu

Referring Practice/Provider:

Practice Name: _____

Provider/Doctor Name: _____

Phone: _____ Email: _____

Patient Information:

Patient's name: _____ DOB: _____ Gender: _____

Home Address: _____

City, State, Zip: _____

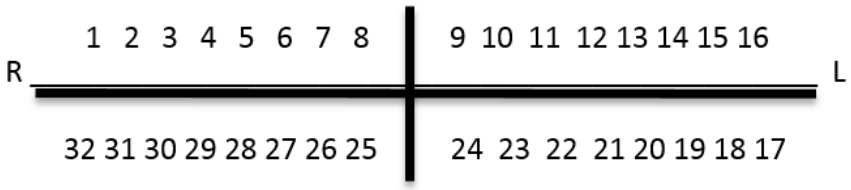
Phone: _____ Email: _____

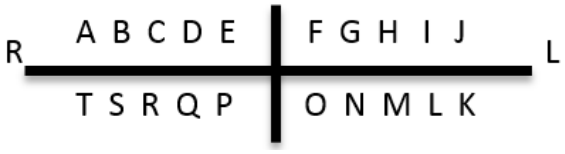
Insurance Plan/Provider: _____

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

☐ Pain	☒ Pathology
☐ Trauma	☐ Sedation
☐ Special Needs	☐ General Anesthesia
☐ Rampant Caries	☐ Interceptive
☐ Behavior/Age	☐ Orthodontic Treatment
☐ Extractions	☐ Other _____

X-Rays: ☐ Available/Enclosed ☐ Sent with patient ☐ Needed





This form is available online at
dentistry.uic.edu/patients/resources