UNMC
BREAKTHROUGHS FOR LIFE.

Patient Information Form

1. Complete the following form and SAVE it where you can easily access it, like on your desktop. You can leave the file name as 'Patient Information Form.'
2. Upload the completed form and radiographs to: unmc.edu/dentistry/patient-care/referrals.html

Referring Clinic Information

Referring Clinic/Doctor: _____

Phone: _____ Email (optional): _____

Patient Information

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth: _____

Patient Insurance Company Information: _____

Department for Referral:

General Dentistry

- ☐ Predoctoral / Comprehensive Care
- ☐ Dentures / Prosthodontics
- ☐ Oral Pathology
- ☐ Hygiene Department

Graduate Department

- ☐ Endodontics
- ☐ Oral Surgery
- ☐ Orthodontics
- ☐ Pediatrics
- ☐ Periodontics / Implants

Root Canal Treatment

- ☐ Predoctoral
- ☐ Graduate
- ☐ No Preference
- ☐ Crown also needed.

Additional Information, including tooth #: _____

_____

Accompanying Radiographs (optional)

Description (BWX, PA, FMX, Pano, Ceph, CBCT)	Date Taken