University Dental Associates (Faculty Practice) Patient Referral Form

Download this form, complete, save, and email (with any accompanying radiographs) to: uda@unmc.edu

Date: _____

Referring Clinic Information

Referring Clinic/Doctor: _____

Address: _____

Phone: _____ E-mail (Optional): _____

Patient Information

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Patient Insurance Company Information: _____

Department for Referral – If you are referring your patient to a specific dental provider, please check their name.

☐ General Dentistry

- ☐ David G. Berkheim
- ☐ Gerard Byrne
- ☐ Jay D. Hansen
- ☐ Robin Hattervig
- ☐ James F. Jenkins
- ☐ Jennifer K. Kallio
- ☐ Myhanh T. Phan-Rinne
- ☐ Joan E. Sivers

☐ Orthodontics

- ☐ Sundaralingam Premaraj
- ☐ Meenakshi (Minnie) Vishwanath

☐ Periodontics / Implants

- ☐ Matthew R. Byarlay
- ☐ Jeffrey B. Payne

☐ Endodontics

- ☐ Hany M. Makkawy

☐ Oral Pathology

- ☐ Peter J. Giannini
- ☐ Nagamani Narayana

Reason for Referral: _____

Additional Information (Optional): _____

Accompanying Radiographs (Optional)

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