University of Nebraska Medical Center
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: https://www.unmc.edu/dentistry/patient-care/referrals.html

Referring Clinic Information

Referring Clinic/Doctor: ______________________________

Phone: ______________________ E-mail (Optional): ______________________

Patient Information

Name: ______________________________

Phone: ______________________ Date of Birth: ______________________

Department for Referral:

☐ Predoctoral / General Dentistry ☐ Orthodontics ☐ Endodontics ☐ Oral Pathology

☐ Periodontics / Implants ☐ Oral Surgery ☐ Pediatrics

Reason for Referral: ______________________________

Additional Information (Optional): ______________________________

Accompanying Radiographs (Optional)

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