UNMC COLLEGE OF DENTISTRY

Patient Referral Form

Instructions: Download this form, complete, save, and then upload the completed form and radiographs to: unmc.edu/dentistry/patient-care/referrals

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