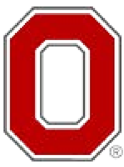

Ohio State
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PROSTHODONTICS PATIENT REFERRAL FORM

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Stephen Rosenstiel BDS, MSD
Paola Saponaro DDS, MS, FACP
Kedith Sawangsri DDS, MS
Soraya Villarroel DDS, MS
Gabriella Zimmer DDS, MS
First Available

Date:

Patient first name: Patient last name:

Date of Birth:

Patient address:

Patient phone: Cell phone:

Full mouth rehabilitation Limited care Consultation

Fixed
Removable
Fixed/Removable
Implant therapy
Comments

Please return patient for general care to referring dentist. Yes No
Are there models available: Yes No

Radiographs:

Enclosed Patient will bring None provided Will be sent On Axium

To transfer patient records and radiographs electronically, please e-mail them to DFPrecords@osu.edu
Please include your office name/phone number, patient name/date of birth and date of radiographs

Referring Dentist:

Address:

Telephone: E-mail:

For directions, go to the Dental Faculty Practice website: smileexperts.osu.edu