Ohio State Dental Faculty Practice

DIVISION OF ORTHODONTICS
REFERRAL REQUEST

Referred By

- ☐ Dr. Henry Fields
- ☐ Dr. Shin-jung (Amber) Hsieh
- ☐ Dr. Ching-Chang Ko
- ☐ Dr. Zongyang Sun

Referred To

Patient Information

Name:

Birth date: Gender ☐ M ☐ F

Address:

Phone:

Dental Ins.:

Medical Ins.:

ID#:

Radiographs:

☐ MAILED ON ☐ PATIENT TO BRING TO CONSULTATION

☐ PLEASE TAKE THE FOLLOWING RADIOGRAPHS

Indicate teeth to be extracted with an X.

			A	B	C	D	E	F	G	H	I	J				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
			T	S	R	Q	P	O	N	M	L	K				

Specific concerns:

Significant Medical History:

Please repair the following caries at this time:

Signature of Referring Provider: Date:

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