Ohio State Dental Faculty Practice

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PERIODONTAL PATIENT REFERRAL FORM

☐ Hsun-Liang (Albert) Chan, DDS, MS ☐ Binnaz Leblebicioglu, DDS, MS, PhD ☐ First available

☐ Guo-Liang Cheng, DDS ☐ Yi-Chu Wu, DDS, MS

Date:

Patient first name: Patient last name:

Date of Birth:

Patient address:

Patient phone: Cell phone:

Patient referred for:
☐ Comprehensive periodontal exam
☐ Limited periodontal consult (please specify below)
☐ Implants in areas indicated below
☐ Other-please specify below

Specific comments:

Restorative plan:

Patient medical history or special considerations:

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