Ohio State Dental Faculty Practice

OROFACIAL PAIN
PATIENT REFERRAL

Hong Chen, DDS, MS

Referred By:

Name:

Facility:

Phone:

E-Mail:

Referral notes, x-rays:

Mailed on (Date)

E-mailed by secure email to DFPrecords@osu.edu
on (Date)

Faxed to 614-292-4960 on (Date)

Please remind the patient to contact MEDICAL insurance company for coverage information PRIOR to the appointment, and to bring MEDICAL insurance card(s) to the appointment.

Patient Information:

Name:

Date of Birth: Sex: ☐ M ☐ F

Address:

Phone:

E-mail:

Medical Ins.:

Subscriber #:

Subscriber Date of Birth:

Dental Ins:

Subscriber #:

Reason for Referral: ☐ Consult ☐ Consult and treatment

☐ Jaw pain ☐ Noise in jaw joint ☐ Face Pain ☐ Locking of Jaw ☐ Headache
☐ Inability to open mouth ☐ Other, specify

Specific concerns:

Signature of Referring Provider: Date:

Thank you for your referral.

Ohio State Dental Faculty Practice | Postle Hall, 2nd Floor | 305 West 12th Avenue | Columbus, Ohio 43210
Phone: 614-292-1472 | Option 2: Scheduling, Option 3: Insurance/Preauthorization
Fax: 614-292-4960 | Secure email: DFPrecords@osu.edu