College of Dentistry
Department of Oral & Maxillofacial Surgery
1395 Center Drive, D1-56
Mailing: P.O. Box 100416
Gainesville, FL 32610-0416

Clinic: 352-273-6731
Clinic Fax: 352-392-6909
Finance & Insurance: 352-273-6725

REQUEST FOR CONSULTATION

Date of Referral_____ Reason for referral: _____

Referring to (Circle one)

M. Franklin Dolwick John H. Hardeman Hamad Alharbi Danielle L. Freburg-Hoffmeister Clayton M. Hamrick First Available

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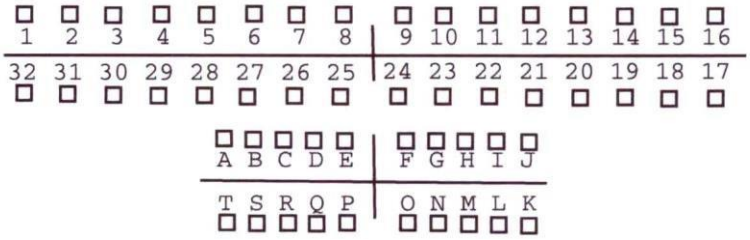
Patient name:_____ DOB_____ M/F _____

Address _____ City, State_____ Zip _____

Home phone _____ Cell phone_____ Guardian _____

If medical, please list referring diagnosis: _____

If referring for extractions please indicate the teeth that need to be extracted. DO NOT say "All".



Radiographs Taken: No ___ Yes ____ If yes, please email to**: Xraysoralsurgery@dental.ufl.edu** (Or have patient bring to appointment)

Referring Dr. _____ **Contact** _____

Address _____ City, State _____ **Zip** _____

Phone _____ Fax _____

First Insurance _____ Phone _____

Policy holder name _____ Policy number _____ Group # _____

Relation to patient _____ Authorization # _____

Second Insurance _____ Phone _____

Policy holder name _____ Policy number _____ Group # _____

Relation to patient _____ Authorization # _____

After completing this form, please mail or fax to our office. Please send all chart notes and diagnostic reports with referral. If you have any questions, please call us at 352-273-6731 or 352-273-6733.