THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

Ohio State Upper Arlington Dentistry
1800 Zollinger Rd., Suite 1200, Columbus, OH 43221
Phone: 614-366-3400, Fax: 614-366-8510
Email: OSUDental-UA@osu.edu

Patient Referral Form

____Urgent Concern ____Evaluation by a Doctor ____Hygiene Appointment

Date: _____

Patient first and last name:_____

Date of Birth:_____

Patient address:_____

Best phone number to reach patient: _____

Insurance Information

If insurance card is available, ***please send with referral***

Primary Dental Insurance:_____

Employer:_____

Policy Holder:_____

Referral Information

Name:_____

Address:_____

Telephone:_____ Fax:_____E-mail:_____

Reason for referral:

To request a secure email through which to transmit referral or patient records, please email OSUDental-UA@osu.edu with “Secure Email Request” in the subject line. A link to communicate via ZixCorp, our data encryption service, will be contained in our reply.

Ohio State Upper Arlington Dentistry
1800 Zollinger Rd., Suite 1200, Columbus, OH 43221
Phone: 614-366-3400, Fax: 614-366-8510
Email: OSUDental-UA@osu.edu