THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

305 West 12th Avenue
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Graduate Periodontics Clinic

Referral Request

Referred By Dr._____ Facility _____

Phone _____ Fax _____

Patient Information Name_____ DOB_____

Address_____Apt. _____

City_____ State_____ Zip_____ Gender_____

Phone_____ Email: _____

Communication Preference: Please circle all that apply: phone text email

Periodontal Exam Fee : $100 X-rays: $118

WE CANNOT ACCEPT FAXED X-RAYS *Additional x-rays may still be required for diagnosis*

PLEASE COMPLETE ALL THAT APPLY

Are there pocket depths greater than 6mm? Y / N Does the patient have restorative needs? Y / N
Has a restorative treatment plan been established for this patient? Y / N (please attach if available)
Does the patient intend to continue restorative treatment with your office? Y / N

Reason for Referral: □ periodontitis □ pocket depths 6mm or greater
□ scaling and root planing (deep cleaning) □ implants
□ sinus lifts/bone grafting □ pathology/biopsy □ recession (gum grafting)
□ crown lengthening □ extractions □ canine exposure (ortho)

Indicate teeth to be extracted with an X. Indicate recommended implant sites with a circle.

			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			

Significant Medical History (required, pre-med needed?_____

Signature of Referring Provider_____ Date_____

NOTE: Patients must bring a photo ID and insurance card to the appointment (approx. 1.5 hour consult). Garage parking fees apply.
Patients should call to schedule at 614-292-4927.
Appointments are available on Mondays, Wednesdays and Fridays 8am-3pm.
Interpreters available upon request. THANK YOU FOR YOUR REFERRAL

***Please email this completed form and any x-rays to:* PeriodonticsClinic@osu.edu**