SIU Dental Associates

PROSTHODONTICS/GENERAL DENTISTRY

PATIENT REFERRAL FORM

Patient Information

Name: _____

Birth date: _____ Gender: ☐ M ☐ F

Address: _____

_____

Phone: _____

Dental Ins: _____

Medical Ins: _____

ID #: _____

Preferred Doctor

☐ First available

☐ Dr. Bret Gruender

☐ Dr. Vincent Rapini

Referred by:

Name: _____

Facility: _____

Phone: _____

Radiographs:

___Enclosed ___Patient will bring ___None provided ___Will be sent ___On AxiUm

To transfer patient records and radiographs electronically, please visit the following URL: https://sdm.siue.edu/xraydropboxfp/uploadxrays.php. Please include your office name/phone number, patient name/date of birth, and date of radiographs.

____Full mouth rehabilitation ____Limited care ____Consultation

Fixed _____

Removable _____

Fixed/Removable _____

Implant Therapy _____

Comments _____

_____

Please return patient for general care to referring dentist. ☐ Yes ☐ No

Are there models available? ☐ Yes ☐ No