THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

Ohio State Upper Arlington Dentistry
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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.