COLLEGE OF DENTISTRY
The UNIVERSITY of OKLAHOMA HEALTH SCIENCES

Pediatric Dentistry Residency Program

1200 N. Children's Avenue, #8F
Oklahoma City, OK 73104
phone: (405) 271-4750 | fax: (405) 271-4058

Today's Date: _____

Patient's Name: _____ _____ _____
Last *First* *Middle Initial*

Date of Birth: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Phone: _____

Reason for Referral:
(Include relevant dental and/or medical histories. Attach additional sheets if necessary.)

_____
_____
_____
_____
_____
_____
_____

Referred by: _____

Phone: _____ **Email:** _____

Please return completed form with available x-rays to peds-dentistry@ou.edu or fax it to 405/271-4058.

Thank you.
It's our privilege to participate in your patient's dental care.