



COLLEGE OF DENTISTRY

REFERRAL FORM

Referral To: **New York University College of Dentistry**
345 E. 24th Street (corner of First Avenue), New York, NY 10010

Referral Date: _____

Patient's Name: _____ Date of Birth: _____

Referred For:

- Endodontics-7W**
To make an appointment please call 212-998-9679
- Implant Dentistry-8W**
To make an appointment please call 212-998-9999
- Oral and Maxillofacial Surgery-Suite 201 S**
To make an appointment please call 212-998-9679
- Oral Mucosal Lesions, Oral-Facial Pain, and TMD-1B**
To make an appointment please call 212-998-9888
- Orthodontics-6W**
To make an appointment please call 212-998-9993
- Pediatric Dentistry-9W**
To make an appointment please call 212-998-9650
- Periodontics-7W**
To make an appointment please call 212-998-9679
- Prosthodontics-5W**
To make an appointment please call 212-998-9679

Requested Procedure(s): **PLEASE PRINT** _____

TO EXPEDITE YOUR PATIENT'S CARE, PLEASE ENCLOSE RADIOGRAPHS AND ANY SPECIAL INSTRUCTIONS.

Referring Dentist's Name: **PLEASE PRINT** _____

Office Address: _____

Office Phone Number: _____

Referring Dentist's Signature: _____

TREATMENT COMPLETION FORM

To be completed by the NYU College of Dentistry

Please return to referring dentist.

Treatment Provided: _____

Resident's Name: _____ **Resident's Signature:** _____ **Date:** _____
PLEASE PRINT

Faculty Name: _____ **Faculty Signature:** _____ **Date:** _____
PLEASE PRINT

Thank you for your referral!

This form may be photocopied.