NYU | DENTISTRY

Specialty Referral Program
NYU 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–5W**
  To make an appointment please call 212–998–9679
- ○ **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 212–998–9679
- ○ **Orthodontics–6W**
  To make an appointment please call 212–998–9679
- ○ **Pediatric Dentistry–9W**
  To make an appointment please call 212–998–9679
- ○ **Periodontics–5W**
  To make an appointment please call 212–998–9679
- ○ **Prosthodontics–4W**
  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

NYU CD PROVIDERS

Thank you for your referral!

This form may be photocopied.