SIU Dental Associates

ORAL PATHOLOGY
PATIENT REFERRAL FORM

Patient Information

Name: _____

Birth date: _____ Gender: ☐ M ☐ F

Address: _____

_____

Phone: _____

Dental Ins: _____

Medical Ins: _____

ID #: _____

Preferred Doctor

☐ First available

☐ Dr. Jasbir Upadhyaya

Referred by:

Name: _____

Facility: _____

Phone: _____

Primary Care Physician (if different from referral doctor):

Name: _____ Phone: _____

Address: _____

_____

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.

Reason for Referral:

Specific concerns:

Significant Medical History (required):

Signature of Referring Provider: _____ Date: _____

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

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