MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Oral & Maxillofacial Surgery / Hospital Dentistry
Patient Referral Form:
TMD and Orofacial Pain

OS West at Community Dental Center
406 North Ashley Street
Ann Arbor, MI 48103
Phone: 734-998-6320
Fax: 734-936-5941

Thank you for your interest in referring a patient to our department. Please complete the information below so that we can triage and most expeditiously provide care for your patient. Fax the completed form to the number above.

DATE: _____

REFER TO:

Nonsurgical TMD & Orofacial Pain

- ☐ Lawrence Ashman, DDS

Surgical TMJ Treatment

- ☐ Sharon Aronovich, DMD, FRCD (C)
- ☐ Christos Skouteris, DMD, PhD
- ☐ No Preference

PATIENT INFORMATION:

Name: _____
Address: _____
City, State _____ ZIP: _____
Phone: _____
Gender: _____
Birthdate: _____
Reg # (UM): _____

Medical Insurance: _____
Dental Insurance: _____

DATE OF OCCURANCE: _____
REASON FOR REFERRAL: _____
_____
_____

REFERRING PHYSICIAN:

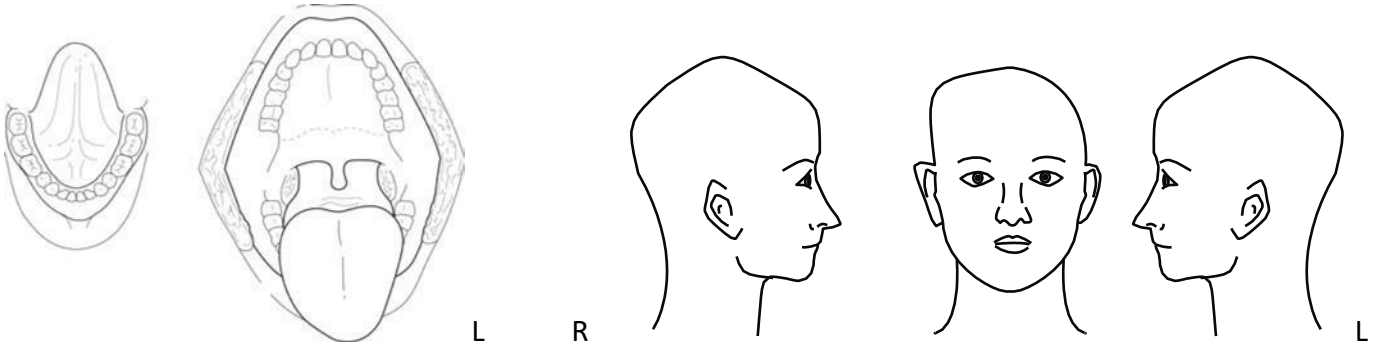
Name: _____
Telephone: _____
Fax: _____
Address: _____
City, State ZIP: _____
Specialty:

- ☐ Primary Care
- ☐ Oral Surgery
- ☐ Orthodontics
- ☐ Dentistry
- ☐ Other: _____

PRIMARY CARE PHYSICIAN:

Name: _____
Telephone: _____
Fax: _____

Please email x-rays to OralSurg-HospDent@med.umich.edu, or have patient bring them at the time of their appointment.



While type of insurance does not affect quality of care, your patient is responsible to know if he/she may be treated at our facility and if an insurance referral is needed from a primary care physician. If these guidelines are not followed, your patient may receive a bill for services rendered. The patient is able to contact member services located on his/her insurance card for more information. Payment for each visit is expected at the time of service for patients with no insurance, insurance coverage that does not pay for the type of treatment we render, and insurance policies we do not accept.

Rev: 08/2019