UCSF Dental Center

Please complete and fax
Please register online at www.ucsfdentalcenter.org and contact our clinic to schedule an appointment
tel: (415) 476-1316
fax: (415) 476-0665

Oral and Maxillofacial Surgery Faculty Practice at Parnassus

_____
Date

Patient Name | **Date of Birth** | **Phone** | **Email Address**

Insurance Information:

Dental Insurance Company_____

Dental Insurance ID# _____

Medical Insurance Company_____

Medical Insurance ID# _____

X-Rays (please choose one):

☐ E-Mailed

☐ Given to patient

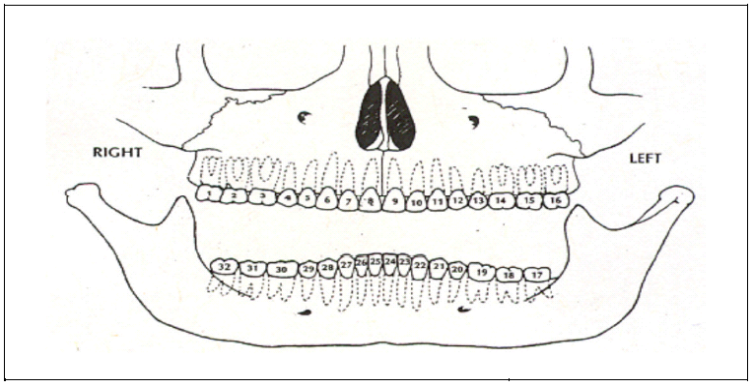
☐ X-Rays Need to be Taken

Is patient under 18 years old? ☐ Yes ☐No

If yes, state contact info: _____
Name of Guardian and Phone Number

Teeth To Be Treated (Please complete both chart and odontogram)

			A	B	C	D	E	F	G	H	I	J			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			



Reason for Referral (Please check all that apply):

- ☐ Wisdom Teeth
- ☐ Implants
- ☐ Other Extraction
- ☐ Orthognathic Surgery
- ☐ Other_____

Notes (Include Preferred Implant System and Preferred Surgeon):

_____

_____

_____

_____

_____

Referring Doctor:

Name | **Phone** | **Email Address**

**Please note: An authorization is required for all medical procedures with patients that have HMO or Welfare Medi-Cal. You can request it from your regular PCP.

**Orthognathic consult: Include without panoramic X-ray, lateral ceph, or PA ceph | CPT Code: 99205, 70355, 70350, 70350A

**For trauma or pathology (radiolucency, cysts or mass): Consultation includes CBCT scan | CPT Code: 99203, 70486