Provider Referral Form

Patient Name: _____ DOB: ___/___/_____

Patient Phone: Home: ____-_____-_____ Cell: ____-_____-_____ Work: ____-_____-_____

Referring Doctor: _____ Phone: ____-_____-_____

Dr. Address: _____ City: _____ State: _____ Zip:_____

Reason for Referral:

- ☐ _____
- ☐ _____
- ☐ _____

Oregon Dental Implant Residency referral location:

_____ Hillsboro
518 SE Oak #100
Hillsboro OR 97123

_____ Prineville
302 NE 7th Street
Prineville, OR 97754

Do you need:

_____ Data Scan with reader software _____ DICOM file only

Comments:

_____

_____

_____

Hillsboro Office
hillsboro@oregondentalimplantresidency.com
518 SE Oak #100
Hillsboro, OR 97123
503.917.0317 ex:1

Prineville Office
prineville@oregondentalimplantresidency.com
302 NE 7th Street
Prineville, OR 97754
503.917.0317 ex:2