



Thank you for your interest in referring a patient to the University of Michigan Oral & Maxillofacial Surgery Department/Hospital Dentistry. 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 listed above.

Date: _____

Refer To:

Nonsurgical TMD & Orofacial Pain

Lawrence Ashman, DDS

Surgical TMJ Treatment

Sharon Aronovich, DMD, FRCD (C)

Stephen Feinberg, DDS, MS, PhD

Christos Skouteris, DMD, PhD

No Preference

Referring Physician:

Name: _____

Telephone: _____

Fax: _____

Address: _____

City, State ZIP: _____

Specialty:

Primary Care

Oral Surgery

Orthodontics

Dentistry

Other: _____

Patient Information:

Name: _____

Address: _____

City, State _____ ZIP: _____

Phone: _____

Gender: _____

Birthdate: _____

Reg # (UM): _____

Primary Care Physician

Name: _____

Telephone: _____

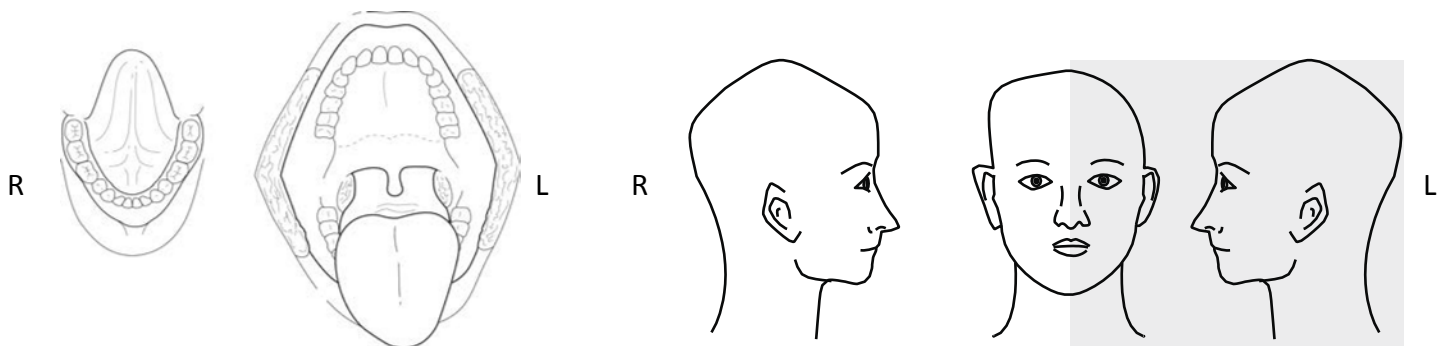
Fax: _____

Date of Occurrence: _____

Reason for Referral: _____

Medical Insurance: _____

Dental Insurance: _____



While type of insurance does not effect 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.

We do not accept the following insurance: BCN Adv, HAP assigned to Henry Ford, DMC, Genesys, or county insurance other than Washtenaw.