East Carolina University
School of Dental Medicine

Referral for Oral and Maxillofacial Diagnostic Services

Diagnostic Service Requested: _____ Pathology _____ Radiology

Patient Information

Patient Name: _____ DOB: _____ /_____ /_____
Last First Middle

Phone # _____ Gender: M or F Race:_____

Referrer Information

Practice/Organization Name: _____

Address: _____

_____

Referring Provider:_____ NPI # _____

Phone Number: _____ Email address: _____

Billing Information

BILL TO: _____Physician's Office/Practice/Hospital _____Insurance _____Patient

Billing Contact Name: _____ Phone Number: _____

Additional Patient Info (Required only if we are billing insurance or the patient directly)

Responsible Party Name: _____ SS#: _____

Primary Insurance: _____

Subscriber Name: _____ Subscriber ID: _____

Relationship to Subscriber: ___self ___spouse ___parent

Secondary Insurance: _____

Subscriber Name: _____ Subscriber ID: _____

Relationship to Subscriber: ___self ___spouse ___parent

(Patient MUST bring their insurance card and ID to their appointment)

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ECU School of Dental Medicine
Dept. of General Dentistry, Oral-Maxillofacial Radiology
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Radiology Requisition Form
To Accompany Radiology Referrals

Patient Name: _____ DOB: _____/_____/_____
Last First Middle

Reason for the scan:

Any pertinent medical/dental history: