IMPLANT DENTISTRY

COLLEGE OF DENTISTRY

801 Newton Rd
Iowa City, Iowa 52242-1001
Tel: 319-335-7169
FAX: 319-335-7351

Use this form for screenings for implant treatment in the predoc and graduate clinics.

Date: ____________________

Patient name: ______________________________ Date of birth: ________________________
Patient address: ____
Home phone: _________________________ Cell phone: ______________________________

Date of Patient's last dental exam/cleaning: ____

Patient has additional tx needs? ☐ Yes ☐ No
If yes, please list: ____

Patient desires: ☐ Faculty/DSP Care or ☐ Resident/Pre-Doctoral Care

Treatment requested:

☐ Implant Placement only for: ____

☐ Implant Placement and Restoration for: _____________________________________

☐ Other/Additional Comments: ____
____
____
____

☐ Please return patient for general care to referring dentist.

Radiographs preferred on film or compact disc:
☐ Enclosed ☐ Will be sent ☐ Patient will bring ☐ None provided

Please contact Implant Dentistry by telephone *(319-335-7169)* or mail *(801 Newton Rd, Iowa City, Ia 52242)* to set up a screening appointment.

Referring Dentist: ____
Address: ____
Telephone: ___________________________ Email: ____________________________________

For additional forms call: 319-335-7169
Or visit website – https://www.dentistry.uiowa.edu/sites/default/files/docs/referral/referral_implant.pdf