



You can refer patients to us by faxing this form to **918.970.4953**.

(If your patient needs immediate assistance, please call 918.970.4944.)

Your first and last name	Your email
Referring Doctor's name	Practice name
Phone	Fax
Patient Information	
Patient Name	Date of birth
Parent / Guardian	Phone no.
Address	City
	Zip:
Name of insured	Date of birth
	SSN#
Dental insurance name	Group / policy no.
Insurance address	Insurance phone
Reason for Referral	
Young uncooperative child with extensive treatment needs	
Child with acute anxiety	
Patient with special needs	
Other	
Follow Up	
Patient is referred for specialty care only	
Patient will establish dental home with On the Cusp Pediatric Dentistry	
Additional information	

Thank you!

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On the Cusp Pediatric Dentistry
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