Complete, print and submit.

Reset Form

MAYO CLINIC

Patient Referral

Mayo Clinic Dental Specialties
200 First Street SW
Rochester, MN 55905

Date Today _____

This form can be faxed to 507-284-8082 or sent as an e-mail attachment with radiographs to **mndentaleexrays@mayo.edu**
Phone: For referrals see numbers listed by specialty
Web site: http://www.MayoClinic.org/dental-rst/medprofessional.html

REQUEST FOR SPECIALTY

Check one below

☐ **Orofacial Pain**
507-538-1691
- K. I. Reid
Reid.Kevin@mayo.edu

☐ **Orthodontics**
507-284-2433
- F. J. Regennitter
Regennitter.Fred@mayo.edu
- J. E. Volz
Volz.John@mayo.edu

☐ **Periodontics**
507-284-4472
- D. A. Assad
Assad.Daniel@mayo.edu
- P. J. Sheridan
Sheridan.Phillip@mayo.edu

☐ **Division of Esthetic and Prosthetic Dentistry**
507-284-2850
- A. B. Carr
Carr.Alan@mayo.edu
- S. Koka
Koka.Sreenivas@mayo.edu
- T.J. Salinas
Salinas.Thomas@mayo.edu

Patient Information: _____
Last Name First Name M.I.

_____
Street Address

_____
City State ZIP Code

☐ Male ☐ Female _____ (____) _____ (____) _____
Birth Date Home Phone Work Phone

Mayo Clinic Number _____

Referring Doctor _____
Name

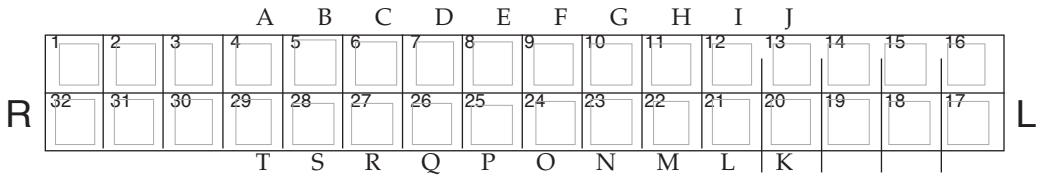
_____
Street Address

_____ (_____) _____
City State ZIP Code Phone

Reason for Referral _____

Requested Doctor _____

X-rays: ☐ Not available ☐ With patient ☐ Being mailed ☐ Electronically mailed



Scheduling Information:
- ☐ Contact patient for appointment
- ☐ Appointment scheduled
- ☐ Patient will call for appointment

For Emergency Treatment:
Monday - Friday, 8 a.m. - 4 :30 p.m.: Call specific specialty at numbers listed above.
All other times: Saint Marys Emergency Department, 507-255-5591.

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