Endodontic Referral Form

PATIENT INFORMATION:

Today's Date___________________

First Name____________________________ Last Name ___________________________________ Date of Birth________________________

Parent / Guardian Name____ Insurance ____________________________

Contact Telephone ____________________________Contact E-Mail Address ____

Does the patient require antibiotics prior to dental treatment? ❏ Yes ❏ No • ❏ Patient will call for appointment ❏ Please call patient

Treatment____

REFERRING DOCTOR'S INFORMATION:

Referred By____ Telephone ________________________________

E-Mail Address ____

FOR CONSIDERATION FOR CONSULTATION AND /OR ENDODONTIC TREATMENT:

Please indicate tooth / area to evaluate____

REFERRED FOR THE FOLLOWING:

❏ Consultation and Diagnosis
❏ Root Canal Treatment
❏ Re–Treatment
❏ Pulp Exposure

PATIENT STATUS:

Frequency of Discomfort .. ❏ None ❏ Occasional ❏ Constant
Nature of Discomfort ..... ❏ None ❏ Vague ❏ Mild ❏ Moderate ❏ Severe
Preferences .... ❏ Examination and Diagnosis only ❏ Examination, Diagnosis and Treatment

OTHER INFORMATION:

❏ Please send additional referral pads
❏ **Please call me:**

Crown / Bridge is Cemented:

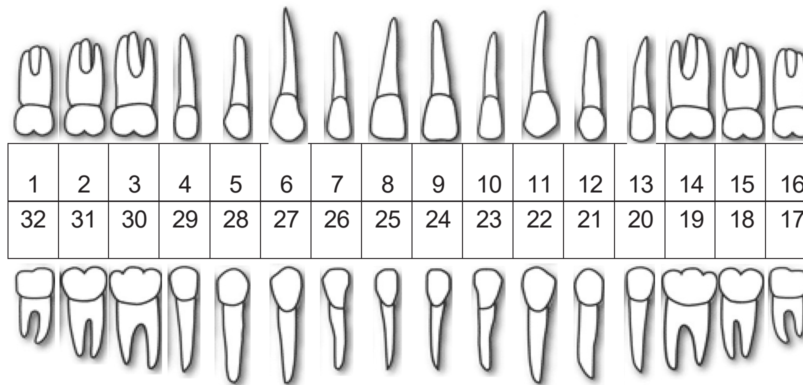
RADIOGRAPHS OR CLINICAL PHOTOS:

❏ Being Mailed
❏ Given To Patient
❏ Please Take
❏ No X–Ray
❏ CBCT
❏ Attached With This Referral; if X-Rays are attached, what date were they taken ___________________

TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM ABOVE OR BELOW.

AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL FORM.

PLEASE MARK TEETH / AREA TO BE TREATED:



POSSIBLE EXTRACTIONS:

CASE NOTES: