

## Endodontic Referral

Please complete this form and fax it to 909.469.8650. Please contact The Dental Center for an appointment at 909.706.3910. We must have this form BEFORE we can schedule an appointment. The cost of the initial appointment ranges from \$66.00-\$157.00.

**PATIENT INFORMATION**

Patient's Name *(Please print)* \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Patient Primary Telephone/Mobile Number \_\_\_\_\_

Other Telephone/Mobile Number \_\_\_\_\_

**REFERRING DOCTOR**

Doctor's Name *(Please print)* \_\_\_\_\_

Practice Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

### RELEVANT CLINICAL INFORMATION

Indicate Tooth Number/Area: \_\_\_\_\_

Indicate treatment that is requested (Check ALL that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Consultation Only             | <input type="checkbox"/> Endodontic Treatment    |
| <input type="checkbox"/> Surgical Endodontic Treatment | <input type="checkbox"/> Endodontic Re-Treatment |
| <input type="checkbox"/> Determine Restorability       | <input type="checkbox"/> Leave Post Space        |
| <input type="checkbox"/> Build-up (Post, if necessary) | <input type="checkbox"/> Crown                   |

Other/Additional Comments: \_\_\_\_\_

### RADIOGRAPHS

Please attach any pertinent radiographs below. Please be advised that additional radiographs may be made at The Dental Center as needed.

### DOCTOR SIGNATURE, DATE AND FAX REQUIRED

Dr. \_\_\_\_\_

Date: \_\_\_\_\_

Fax: \_\_\_\_\_