Please bring this referral to your appointment

Introducing ______________________________

Patient Phone ______________________________

Appointment Date ____________________ Time ______________

1 2 3 4 5 6 7 8 : 9 10 11 12 13 14 15 16

Right Side--Left Side

32 31 30 29 28 27 26 25 : 24 23 22 21 20 19 18 17

Remarks ______________________________

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Referring Doctor ______________________________

Office Phone ____________________ Date ______________

Referring Requests:

- ❑ Consult and Treat as Necessary
- ❑ Root Canal Treatment
- ❑ Root Canal Retreatment
- ❑ Apicoectomy
- ❑ Assist with Diagnosis
- ❑ Please Call: ❑ Before Consult
  ❑ After Consult

Dental History:

- ❑ Pain
- ❑ Generalized Pain UR LR UL LL
- ❑ Pulp Exposure
- ❑ Trauma
- ❑ Previously Opened
- ❑ Possible Root Fracture / Crack
- ❑ Apical Pathology
- ❑ Other ______________

Requested Restoration:

- ❑ Post Space
- ❑ Restore Access
- ❑ Post Buildup
- ❑ Buildup
- ❑ Other ______________

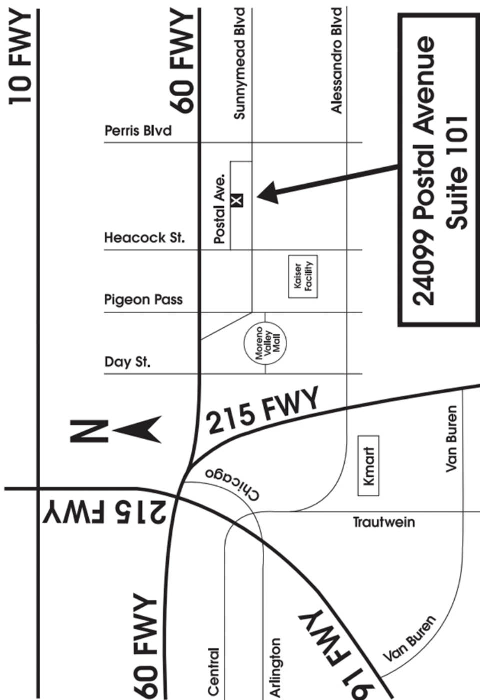
3-D CBCT Imaging:

Maxillary Arch: ❑ Tooth# ________

Mandibular Arch: ❑ Tooth# ________

❑ Panorex

This time is reserved exclusively for you. Please notify the office 24 hours in advance if you are unable to keep your appointment. We are looking forward to meeting you.



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