

|  |
| --- |
| PATIENT INFORMATION |
| Date: | Click here to enter text. |
| Patient Name: | Click here to enter text. |
| Home/ Cell Phone: | Click here to enter text. |
| Office Phone: | Click here to enter text. |
| REFERRING DOCTOR INFORMATION |
| Referred By: | Click here to enter text. |
| Phone: | Click here to enter text. |
| Email: | Click here to enter text. |

*PLEASE MARK THE FOLLOWING TREATMENT*

|  |  |
| --- | --- |
| [ ]  Root Canal | [ ]  Leave Post Space |
| [ ]  Retreatment | [ ]  Place Post and Core |
| [ ]  Place Composite Core | [ ]  Please call patient to arrange appointment |
| [ ]  Consultation & Diagnosis | [ ]  Patient will call you to arrange appointment |
| [ ]  Apicoectomy / Retrograde | [ ]  Please send more referral pads |
| [ ]  Pulpal Exposure | [ ]  Please call me |

*PLEASE MARK TEETH OR AREA TO BE EVAULATED*

UPPER

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

 LEFT

 RIGHT

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

LOWER

**REFERRING DOCTORS - To ensure a smooth patient transition, please have your front desk staff call to schedule the patient’s appointment, fax the referral form to 940-228-4148 or email this referral form to info@WichitaFallsEndo.com**