WICHITA FALLS ENDODONTICS

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REFERRAL FORM

PATIENT INFORMATION	
Date:	
Patient Name:	
Home/ Cell Phone:	
Office Phone:	
REFERRING DOCTOR INFORMATION	
Referred By:	
Phone:	
Email:	

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

RIGHT LEFT

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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.