Doctor Referral

Patient Information

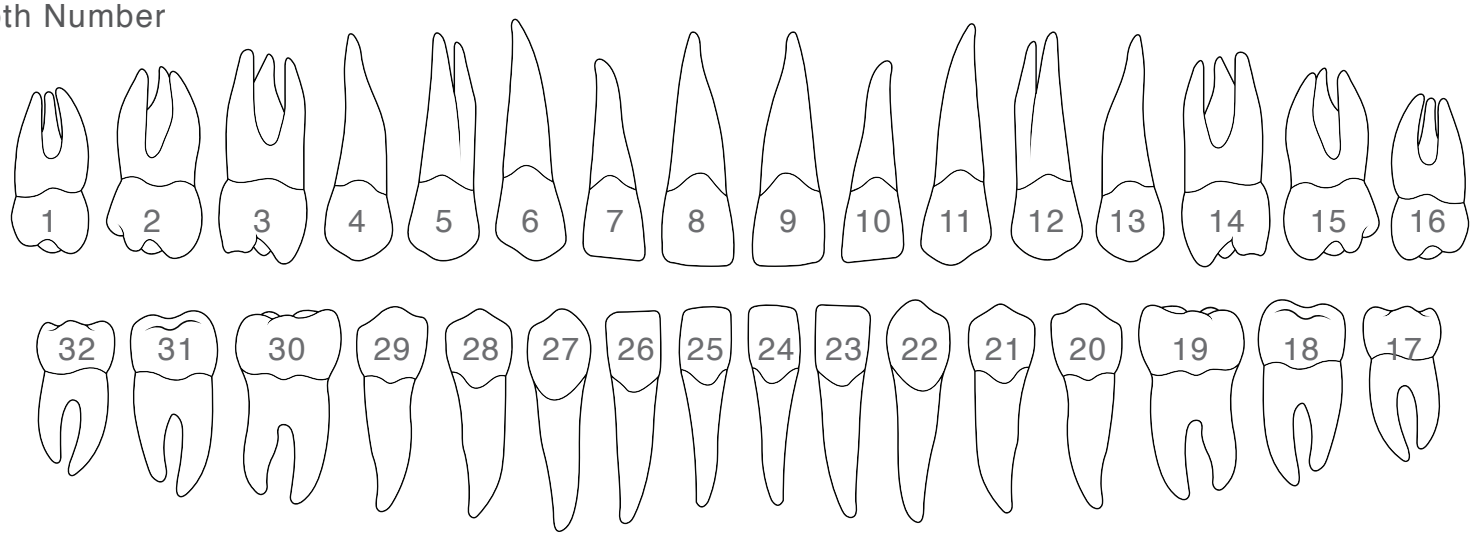
First Name: | Last Name: | DOB: | PH:

Address: | City: | State: | Zip:

Referring Doctor Information

Referred By: | PH: | Email:

Tooth Number



Tooth Number(s):

Appointment Type

- ☐ Evaluate Only
- ☐ Tooth is ready for treatment - please treat
- ☐ Evaluate for non-surgical retreatment and/or surgery
- ☐ Root canal started on:

Treatment Instructions

- ☐ Patient requires a premedication and has a prescription
- ☐ Place permanent restoration:
  - ☐ Amalgam ☐ Composite
- ☐ Create post space
- ☐ Refer patient back to our office for permanent restoration

Radiographs or Clinical Photos

☐ Being Mailed ☐ Given to Patient ☐ Please Take ☐ No X-Ray

Appt. Date & Time:

Case Notes