



M I D T O W N E N D O D O N T I C S

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Patient: _____ D.O.B _____ Referral Date: _____

Patient Phone #: _____ Patient Email: _____

Referring Dr. _____ Office Phone #: _____

Referring Dr. Email: _____ Patient is (Please circle):

Appt Date/Time: _____ New / Existing

Radiographs are (please circle): Emailed / Mailed / Sent with Patient

Preference of Contact for Final Report (please circle): Email / Fax / Mail



Reason for Referral:

- Evaluate only
- Evaluate / Treat as Needed
- Evaluate for Endodontics Surgery
- Take CBCT Scan

Restorative Instructions:

- Place Post and / or Build-Up
- Leave Post Space
- Place Cavit or IRM in Access Cavity

Definitive Endodontic Treatment Needed:

- Periapical Radiolucency Present
- Pulp Exposure / Tooth Prev- Opened
- RCT Required for Proper Restoration
- Previous Endo

Miscellaneous:

- Crown / Bridge is Cemented Temp
- Crown / Bridge is Cemented Perm
- Call to discuss
- Possible Fracture

Insurance Subscriber: _____

Carrier _____

Subscriber DOB: _____ Subscriber ID: _____

Additional Notes: _____