West Coast Endodontics

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PATIENT REFERRAL

Patient Name ______________________ Phone ______________
Insurance ______________________ DOB ______________
Referring Dr. ______________________ Date ______________
Appointment Date ______________________ **Time** ______________

Tooth # (Area) ______________________

- ☐ Consultation Only
- ☐ Consultation and Treatment
- ☐ Previous Root Canal Treatment How Long Ago? ______________

Restorative Plans ______________________

Please indicate post-treatment coronal seal preference

- ☐ Temporary Filling Only
- ☐ Leave Post Space
- ☐ Coronal build-up with Amalgam or Composite
- ☐ Other

Health History: Any serious health concerns? ______________________

Any reason to pre-medicate? ☐ Yes ☐ No

Will patient need oral sedation? ☐ Yes ☐ No

Comments ______________________

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☐ Please send additional referral pads