562 endodontics

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PATIENT REFERRAL FORM

Today's Date _____

○ **Dr. Jacqueline Lopez Gross**, DDS, MSc, FRCD (C)

○ **Dr. Manfred Friedman**, B.D.S (Wits.) B.Ch.D Hons (Pret) ○ **Dr. R. Gregory Carr**, DDS

REFERRING DOCTOR * REQUIRED FIELDS

* Office Number * Dr.'s First Name * Last Name

* Office Name * Email

PATIENT INFORMATION * REQUIRED FIELDS

* First Name * Last Name

* Cell Phone * Home Number * Email

* Date of Birth YYYY/MM/DD * Parent/Guardian/Relative

* Records ○ Periapical ** ○ Bitewing ** PLEASE SEND THE MOST RECENT PERIAPICAL AND BITEWING IF AVAILABLE

REFERRED FOR

○ Consult Only ○ Consult and Treatment as Needed ○ Emergency Appointment

○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

TOOTH STATUS • When _____

- ○ Previous RCT - Initiated RCT
- ○ Symptomatic
- ○ Asymptomatic
- ○ Fractured Tooth/Restoration
- ○ Severe Pain/Swelling
- ○ Trauma
- ○ Sinus Tract

RESTORATIVE TREATMENT PLANNED

- ○ Direct Restoration
- ○ Crown

RESTORATION AFTER TREATMENT

We will restore with Fuji to keep as a base for the composite core unless you prefer:

- ○ Leave Post Space
- ○ Restore with Post and Core
- ○ Restore the Core

INSURANCE INFORMATION

Company Member ID/Policy # Group Number #

Policy Holder Policy Holder: Date of Birth YYYY/MM/DD

Policy Holder Address

SPECIAL CONSIDERATIONS (Relevant Medical Condition, Accommodation, Dental Anxiety, Urgent Matter, Staff Member, Doctor's Relative, etc.)