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PATIENT REFERRAL FORM

Email this form to info@562endodontics.com

Today's Date _____

- Dr. Jacqueline Lopez Gross**, DDS, MSc, FRCD (C)
- Dr. R. Gregory Carr**, DDS
- Dr. Manfred Friedman**, B.D.S (Wits.) B.Ch.D Hons (Pret)
- Dr. Inés Marín Betancourt**, DDS, FRCD (C)

REFERRING DOCTOR * REQUIRED FIELDS

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

* Office Name _____ * Email _____

PATIENT INFORMATION * REQUIRED FIELDS

* First Name _____ * Last Name _____

* Preferred Phone Number _____ * 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

<input type="radio"/>															
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
<input type="radio"/>															
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

TOOTH STATUS

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

RESTORATIVE TREATMENT PLANNED

- Direct Restoration
- Crown

RESTORATION AFTER TREATMENT

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

- Leave Post Space
- Restore with Post and Core
- Restore the Core
- Sponge + Glass Ionomer

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.)
