562 endodontics
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(519) 601 36 36
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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. 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

○ 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.)