DENTON ENDODONTICS

J. Brandon Carroll, DDS

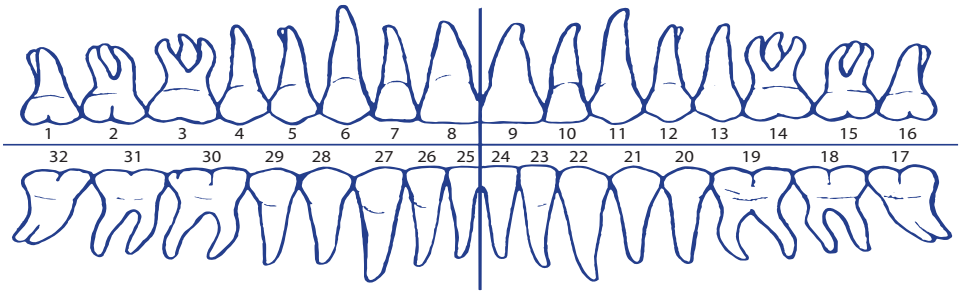
PATIENT REFERRAL FORM

Patient name: _____ Primary phone: _____

Referred by Dr. _____ On: _____ (Date)

Appointment scheduled for: _____ (Date) At: _____ (Time)

Teeth/Area To Be Treated



Symptoms/Findings

- ❑ Hot/Cold Sensitivity
- ❑ Biting/Pressure Sensitivity
- ❑ Constant Pain
- ❑ Vague Toothache/Pain
- ❑ Swelling
- ❑ Sinus Tract
- ❑ Radiograph Reveals Endodontic Pathosis
- ❑ Pulp Exposure
- ❑ RCT Required for Proper Restoration
- ❑ Previous Root Canal Treatment
- ❑ Trauma with Pulpal/Periapical Involvement
- ❑ Other: _____

Please Complete

- ❑ Evaluation Only
- ❑ Evaluation and Necessary Treatment
- ❑ Root Canal Treatment
- ❑ Non-surgical Retreatment
- ❑ Surgical Treatment
- ❑ Other: _____
- ❑ Restorative
  - ❑ Prepare Post Space
  - ❑ Core Buildup with _____
  - ❑ None (Please Return Patient for All Restorative)

Special Instructions or Comments: _____

_____

_____

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