endodontics

SMILEWORKSHOP®
DENTAL SPECIALISTS

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patient referral

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

Please call to schedule your patient's appointment

Introducing: ______________________ Patient Phone: ______________

Appointment Date & Time: ______________________________

Date: __________ Referring Dr. ______________ Phone: ______________

Please check all that apply:

- ☐ Thermal Sensitivity
- ☐ Bite Sensitivity
- ☐ Swelling
- ☐ Radiograph reveals radiolucency
- ☐ Tooth previously opened
- ☐ Pulpal Exposure
- ☐ Endodontics necessary for restoration
- ☐ History of crack or fracture
- ☐ Previous trauma
- ☐ Previous treatment appears to be failing
- ☐ Patient has unlocalized pain in the area indicated.
- ☐ Place final restoration in access
- ☐ Create post space

☐ Evaluate & Treat ☐ Evaluate Only

Comments:

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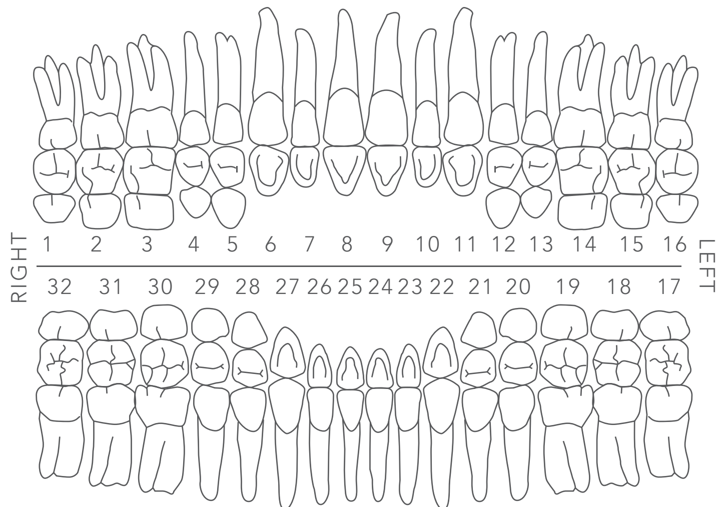
- ☐ Please call me before proceeding with treatment
- ☐ I have sent radiographs for your evaluation



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