2225 NW Shevlin Park Rd.
Suite #140
Bend, OR 97703
P: 541-209-0217

SUMMIT
ENDODONTICS

www.Summitendobend.com
info@summitendobend.com

ENDODONTIC REFERRAL FORM

Patient Name: _____ DOB:_____

Patient Phone Number:_____ Date:_____

Referred by Dr. _____ Tooth #:_____

Dental Insurance to bill: Yes or No (if yes, please provide below)

Primary Dental Insurance-
Insured:_____
Insured's DOB:_____
Carrier:_____
Group #:_____
Member ID:_____

Secondary Dental Insurance-
Insured:_____
Insured's DOB:_____
Carrier:_____
Group #:_____
Member ID:_____

Please do not take pain medications within 6 hours or your exam appointment.

PLEASE PERFORM THE FOLLOWING SERVICE:

- ☐ 3D Scan & Exam/Consultation Only
- ☐ Diagnose and Treat As Indicated
- ☐ Endodontic Retreatment or Surgery

Treatment Considerations:

- ☐ Previous Endo Treatment
  Previous Endo Treatment Date:_____
- ☐ Pulp Exposure
- ☐ History of Trauma

Restore Access:

- ☐ Temporary
- ☐ Permanent
- ☐ Post and Core
- ☐ Leave Post Space

Please send radiographs to:

info@summitendobend.com