FOREST CITY ENDODONTICS

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Referral Introduction

Date: _____

Patient: _____ **DOB:** _____

TEL: (H) _____ **(W)** _____ **(C)** _____

Referring Dentist: _____

Please send xrays via CDA Secure Send or email to info@forestcityendo.com

Reasons for Referral:

Tooth # _____

- ☐ Patient has pain and/or swelling
  - ☐ Emergency treatment needed ASAP
- ☐ Tooth previously opened
- ☐ Retreatment
- ☐ Medical Health Alert
- ☐ CBCT (reason) _____
- ☐ Other (specify) _____

Treatment Requested:

- ☐ Consultation /Assessment
- ☐ RCT/ Treatment
- ☐ Post Space required
- ☐ Other (specify) _____

Comments:

_____

_____

_____

Referring DDS signature _____