PATIENT REFERRAL FORM

DALLAS UPTOWN ENDODONTICS

(Practice limited to Endodontics only)

4144 N. Central Expressway
Suite 905
Dallas, TX 75204

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★ **In-Network with Most Insurance Plans**

Phone: (214) 826-2364
Fax: (214) 826-2331
www.dallasuptownendodontics.com

Patient's Name: _____

Patient's Phone #: _____

Referred By: _____

Doctor's Phone #: _____

Tooth # or Area: _____

ENDODONTIC CONSIDERATIONS

- ☐ Pain / Discomfort
- ☐ Periapical radiolucency
- ☐ Pulp exposure
- ☐ Endodontic treatment initiated
- ☐ Previously Treated
- ☐ Trauma
- ☐ Please call before initiating treatment

TREATMENT REQUIRED

- ☐ Evaluation only
- ☐ Root canal treatment
- ☐ Retreatment
- ☐ Consider surgical endodontics
- ☐ Place temporary restoration
- ☐ Permanent build up
  - ☐ Composite
- ☐ Leave post space

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Remarks: _____

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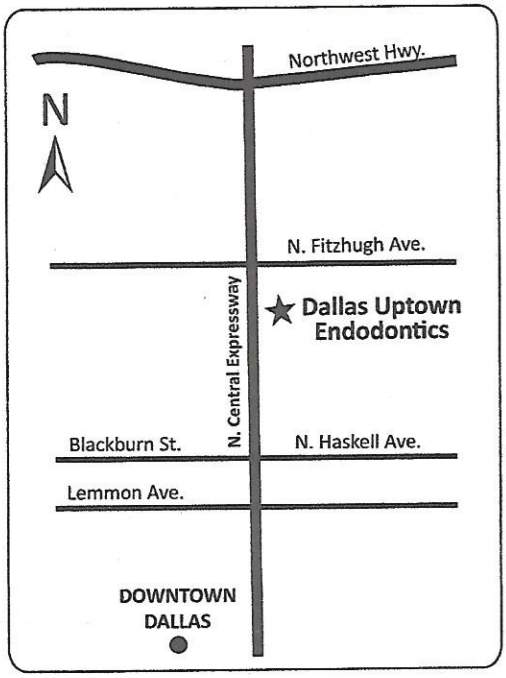
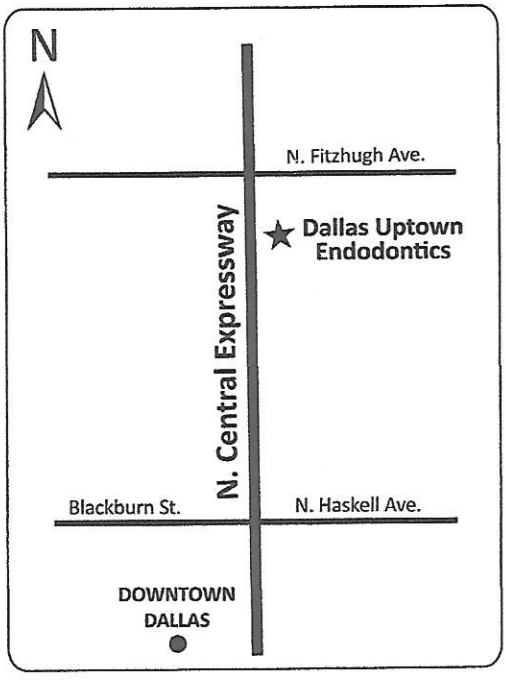


AERIAL VIEW



DETAIL VIEW