TEXAS ROOTS ENDODONTICS
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REFERRAL FOR ROOT CANAL

Date: _____

Patient Name: _____

Date of Birth: _____

Insurance Name: _____

Member ID or SSI #: _____

Home or Mobile Phone: _____

Referring Doctor Name: _____

Office Phone: _____

Tooth #: _____

Remarks / Notes: _____

_____

_____

_____

_____

REASON FOR REFERRAL:

- o Patient has discomfort
- o Previously opened
- o Pulp exposure
- o Periapical pathosis

TREATMENT REQUIRED:

- o Root canal
- o Retreatment of root canal
- o Surgery

RESTORATION CEMENTED:

- o Temporary
- o Permanent

PLEASE PLACE:

- o IRM temp filling
- o Composite
- o Build-up

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