ADVANCED ENDODONTICS

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PATIENT REFERRAL INFORMATION

Name: _____ Date: _____

Patient's Cell Phone: _____ Patient's Birthdate: _____

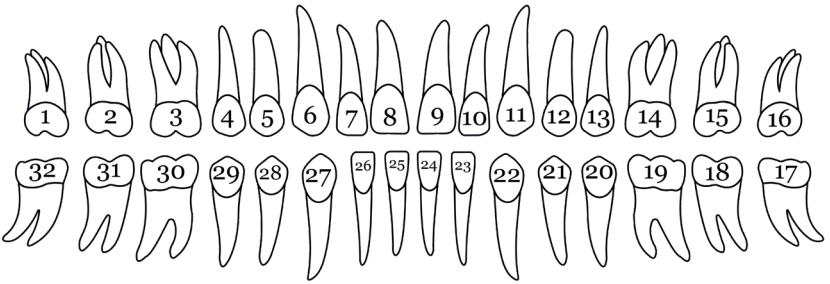
Referred by Dr. _____ Office/Phone: _____

NOTE TO PATIENTS: Please complete our online forms/consents prior to your appointment at www.advancedendodonticsnc.com

Please Check One ☑:

- ☐ Patient will call for Appointment
- ☐ Patient already has an appointment on: (Date): _____
- ☐ Please call patient for appointment

PLEASE CIRCLE THE AFFECTED TOOTH OR AREA



HISTORY: _____

_____

SYMPTOMS ☑:

- ☐ No Symptoms/Periapical Radiolucency
- ☐ Hot/Cold Sensitivity
- ☐ Biting/Pressure Sensitivity
- ☐ Spontaneous Pain
- ☐ Swelling
- ☐ Sinus Tract

TREATMENT REQUESTED ☑:

- ☐ Examine and Treat as Necessary
- ☐ Surgery Consultation
- ☐ Place Permanent Restoration
- ☐ Leave Post Space

PLEASE E-MAIL RADIOGRAPHS TO: STAFF@ADVANCEDENDODONTICSNC.COM