TEXAS ENDODONTIC CENTER

PATIENT REFERRAL FORM

Date: _____ Insurance: _____

Patient Name: _____ Policy Holder: _____

DOB: _____ Group #: _____

Phone Number: _____ ID #: _____

Referring Office/Doctor
and Contact Email: _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Right Quad **Left Quad**

Reason for Endodontic Referral

- ☐ Toothache/ Pain/Swelling
- ☐ Pulp Exposure/Previous Pulpotomy/RCT
- ☐ Endodontic Necessary for Proper Restoration
- ☐ Periapical Pathosis
- ☐ CBCT - 3D Scan

After Endodontic Referral

- ☐ Cavit/IRM/Temp Filling
- ☐ Prepare Post Space
- ☐ Core Build-up/Composite
- ☐ Cement Post and Core Build Up

We see emergency patients!

Comments: _____

Allen Location
107 Suncreek Dr. Ste 120
Allen, TX 75013
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(F) 972.370.3556
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Wylie, TX 75098
(P) 972.818.5090
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Ft. Worth, TX 76244
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(F) 817.947.0754
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