ENDODONTIC ASSOCIATES OF AUSTIN

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Yogesh Patel, D.D.S.
Dr. Ruma Rane

Referral Form

Date:_____
Patient Name:_____
Date of Birth:_____
Insurance Name:_____
Member ID or SSI#:_____
Home & Mobile Phone:_____

Home Main Dentist Office:_____
Office Phone:_____

Referring Doctor Name:_____

Tooth #:_____

Remarks / Notes:_____
_____
_____
_____

REASON FOR REFERRAL:

- □ patient has discomfort
- □ previously opened
- □ pulp exposure
- □ periapical pathosis

TREATMENT REQUIRED:

- □ root canal
- □ retreat root canal

RESTORATION CEMENTED:

- □ temporary
- □ permanent

PLEASE PLACE:

- □ IRM temp filling
- □ composite
- □ build-up