ENDODONTIC

EAST ALABAMA associates

Root Canal Specialists

William B. Looney, D.M.D.
B. Franklin Kimbell, Jr., D.M.D.

In loving memory of Dr. James P. Hannahan

Date: _____ Referring Dentist: _____

To assist us with the care of your patient, please complete this entire referral form.

Patient Name: _____

Appointment Date: _____ Time: _____ A.M. / P.M.

ENDODONTIC CONSIDERATION FOR THE FOLLOWING:

TOOTH / TEETH: _____

PLEASE CHECK ALL THAT APPLY

REFERRAL REQUEST

○ Evaluation ○ Evaluation for Retreatment

○ Endodontic Therapy ○ Apicoectomy

POST TREATMENT RESTORATION TYPE

○ Cavit ○ Post space

INDICATIONS FOR REFERRAL

○ PARL on x-ray ○ Necessary prior to restoration ○ Pulpotomy completed

○ Carious exposure ○ Non-symptomatic ○ Hot and Cold sensitive

○ Palpation sensitive ○ Percussion sensitive ○ Bite sensitive

○ Fistula Present ○ Recent TX (note below) ○ Medication given (note below)

Referring Dentist Signature _____

Additional Notes: _____

_____

_____

COMPLETE PATIENT REGISTRATION FORM ONLINE AT:
www.eaendo.com

ENDO ASSOCIATES-EAST ALABAMA

333 Samford Village Court • Suite A • Auburn, Alabama 36830
T: (877) 481-7804 • F: (334) 297-3913
info@eaendo.com

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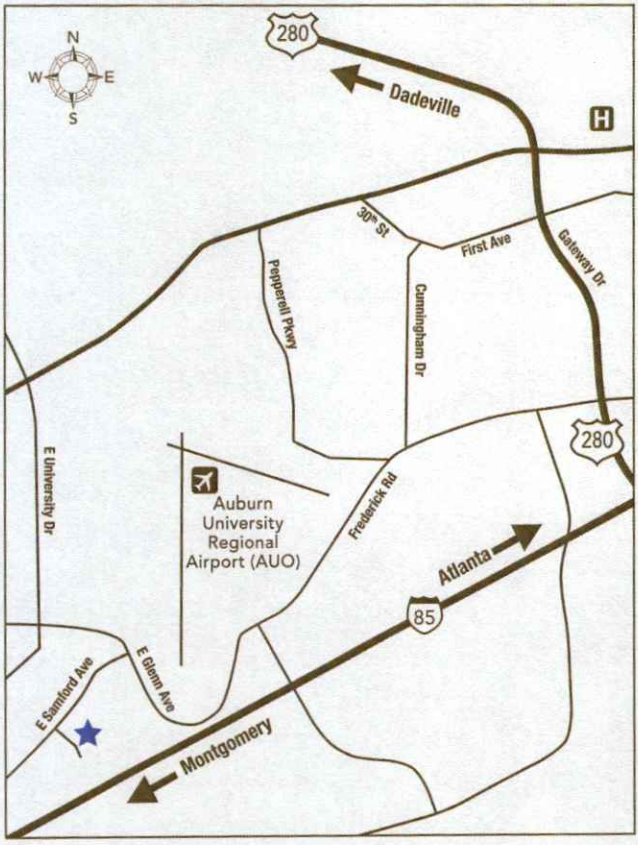

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