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PATIENT REFERRAL

First Name		**Last Name**	
Birth Date		**Phone #**	

Check all that apply:

- ☐ Consultation
- ☐ Endodontic Therapy
- ☐ Endodontic Retreatment
- ☐ Endodontic Surgery (Apicoectomy)
- ☐ Resorption
- ☐ Vital Pulp Therapy/Pulpotomy
- ☐ Other _____

Restorative:

☐ Temporary Filling ☐ Post Space ☐ Composite

Please Indicate Tooth to be Treated

☐ 01	☐ 02	☐ 03	☐ 04	☐ 05	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15	☐ 16
32 ☐	31 ☐	30 ☐	29 ☐	28 ☐	27 ☐	26 ☐	25 ☐	24 ☐	23 ☐	22 ☐	21 ☐	20 ☐	19 ☐	18 ☐	17 ☐

☐ A	☐ B	☐ C	☐ D	☐ E	☐ F	☐ G	☐ H	☐ I	☐ J
T ☐	S ☐	R ☐	Q ☐	P ☐	O ☐	N ☐	M ☐	L ☐	K ☐

Remarks:

Referring Provider Signature		**Date**	
Printed Name			
APPOINTMENT INFORMATION			
Date		**Time**	

1. CBCT will be taken at initial appointment.
2. Consultations will occur on a separate day prior to Surgeries & Re-Treatment.
3. Grandville Endodontics will take their own x-rays.
4. Patients should provide insurance info prior to appointment.
5. Payment is required at time of service. Payment plans are available upon request.
6. Patient will be returning to referring dentist for final restoration, unless indicated above.