VAN GORDON ENDODONTICS

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Specialist in Endodontics
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Patient Name: _____ Phone: _____ Date: _____

Referred by Dr: _____ Office Phone: _____

Referring doctor please check options: **Tooth #:** _____

HISTORY:

- ☐ Previous Treatment
- ☐ Patient is in pain
- ☐ Fistula
- ☐ Swelling
- ☐ Hot / Cold
- ☐ Pressure / Tenderness
- ☐ Radiolucency
- ☐ Other _____

TREATMENT REQUESTED:

- ☐ Consultation & Diagnosis
- ☐ Endodontic Treatment
- ☐ Retreatment
- ☐ Surgical Evaluation / Apico

COMPLETE WITH:

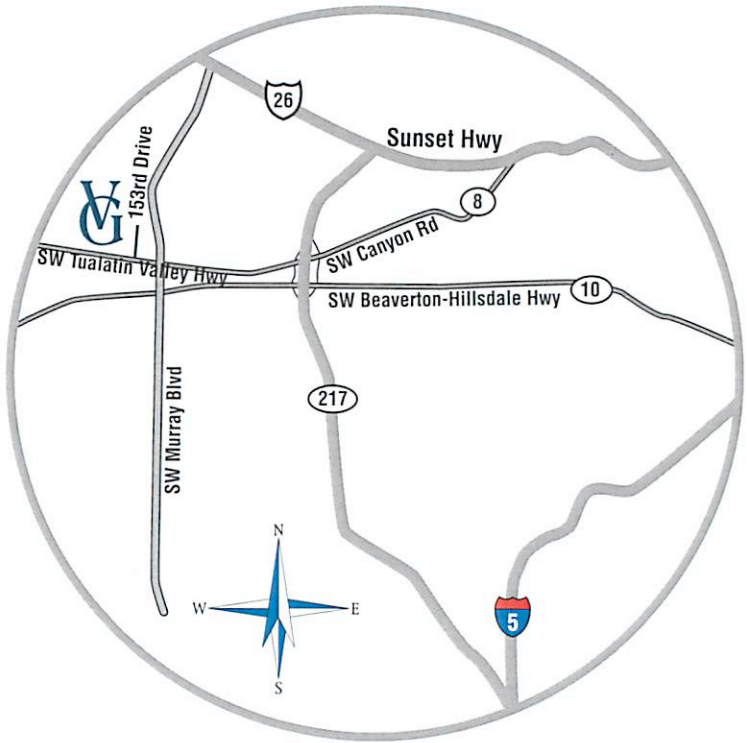
- ☐ Temporary Filling
- ☐ Core Buildup
- Orifice Barrier: yes ☐ no ☐
- Post Prep: yes ☐ no ☐

Remarks / Restorative Plan: _____

_____

- ☐ Please call patient to arrange appointment
- ☐ Patient will call you to arrange appointment
- ☐ Email x-rays to *vgendo.manager@gmail.com*

REFERRING OFFICE:
PLEASE FAX OR EMAIL COMPLETED REFERRAL FORM



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OFFICE HOURS:
Monday - Thursday: 7:30am - 4:00pm
(By appointment only)