BEAVERCREEK ENDODONTICS

Emily Lammers, DDS, MS, Inc.
Kristy Bultema, DDS, MS

Patient's Name: _____

Date of Birth: _____

Daytime Phone: _____

☐ Please call patient ☐ Patient will call to schedule

Radiographs: ☐ Mailed ☐ Emailed ☐ Sent with patient

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

Reason for Referral:

☐ Please evaluate to determine if treatment is necessary

☐ Patient has pain, sensitivity or swelling

☐ X-ray reveals pathology

☐ Evaluate for Retreatment or Apical Surgery

☐ Endodontics necessary for proper restoration

☐ Other: _____

Restoration:

☐ Cotton/Cavit Only ☐ Orifice barrier + temporary

☐ Post space ☐ Other: _____

Remarks: _____

_____

_____

Dr. Signature: _____

Date: _____ Office Phone:_____

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White: Mail/Email/Fax Yellow: Referral's copy Pink: Patient's copy