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## Referral Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Member ID/SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Home Dental Office: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Referring Doctor Name: \_\_\_\_\_

Tooth #: \_\_\_\_\_

Remarks / Notes:

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### 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