amber endodontics

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Patient Referral Form

☐ **DR. AMBER CHU** *(PRACTICE LIMITED TO ENDODONTICS)*

☐ **DR. JEFFREY CHU** *(PRACTICE LIMITED TO PERIODONTICS & IMPLANTOLOGY)*

DATE: _____ REFERRING DOCTOR: _____

PATIENT NAME: _____ DOCTOR PHONE: _____

PATIENT PHONE: _____ DOCTOR FAX: _____

APPOINTMENT DATE: _____ TIME: _____ ☐ A.M. / ☐ P.M.

I AM REFERRING THIS PATIENT FOR: TOOTH#: _____

Endodontics

☐ Evaluation for Root Canal ☐ Retreat -- Root Canal ☐ Others: _____

☐ Root Canal ☐ Emergency / Abscess _____

RESTORATION PREFERENCE:

☐ TEMPORARY FILLING ☐ PERMANENT RESTORATION ☐ POST & CORE ☐ POST SPACE: _____MM

Peridontics & Implants

☐ Periodontal Examination and Treatment

☐ Dental Implants

-- Type of System Preferred:

- ☐ ***Nobel BioCare***
- ☐ ***Straumann***
- ☐ ***Zimmer Compatible***

☐ Recession / Gum Grafting

☐ Extractions / Wisdom Teeth

☐ Oral Lesions / Biospy

☐ Sedation

☐ Crown Lengthening

☐ Frenectomy

☐ Ridge Augmentation

☐ Sinus Lift

☐ Impacted Tooth

☐ Orthodontic Tooth Exposure

☐ Others: _____

_____

REASON(S) FOR REFERRAL & COMMENTS:

_____

_____

_____

_____

We Sincerely Thank You for the Referral!