amber endodontics

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Patient Referral Form

Dr. Kala Morales, DDS, MSD

(PRACTICE LIMITED TO ENDODONTICS)

REFERRING DOCTOR: _____

DATE: _____ DOCTOR PHONE: _____

PATIENT NAME: _____ DOCTOR FAX: _____

PATIENT PHONE: _____

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

REASON(S) FOR REFERRAL & COMMENTS:

_____

_____

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We Sincerely Thank You for the Referral!