GREGORY S. MYERS DDS, MS, INC.

Referral Information to be Filled in by Referring Doctor

Today's Date: _____

Referring Dentist: _____

Patient's Name: _____

Tooth Number or Area in Question: _____

R	1 2 3	4 5	6 7 8	9 10 11	12 13	14 15 16	L
	32 31 30	29 28	27 26 25	24 23 22	21 20	19 18 17	

Reason for Referral (Please Check Box)

- ☐ Patient having pain, swelling, or, sensitivity
  Please schedule root canal treatment
- ☐ Patient having vague symptoms. Please evaluate and treat as needed
- ☐ Endodontics is necessary for proper restoration
- ☐ Radiograph reveals pathosis
- ☐ Pupal exposure
- ☐ Endodontic retreatment
- ☐ Trauma
- ☐ Apicoectomy

Tooth Information:

If the tooth has a restoration, has it been replaced recently?

☐ Yes ☐ No

Does the tooth have a crown?

☐ Yes ☐ No ☐ Permanent ☐ Provisional

Has endodontic treatment been started?

☐ Yes ☐ No

Are any of the following present in the tooth?

☐ Post ☐ Separated Instrument ☐ Silver Points

Please prepare a post space

☐ Yes ☐ No

Please restore the access opening/perform the crown build up

☐ Yes ☐ No

Doctor, please use the reverse side to give us any additional information that may help us better care for your patient.

Appointment Date: _____

Appointment Time: _____

Additional Notes: _____

GREGORY S. MYERS DDS, MS, INC.

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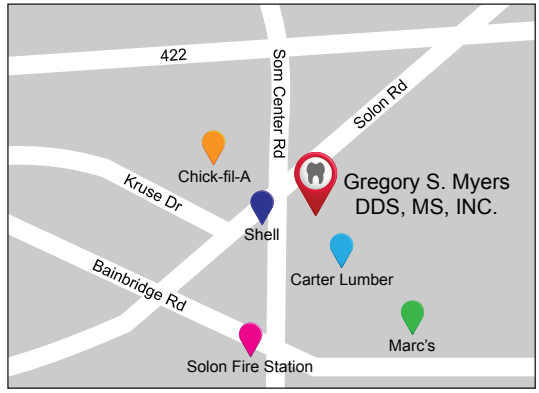

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