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Date: _____

Patient's Name: _____

Patient's Contact: _____

Referred By:

Doctor: _____

Contact: _____

## Teeth To Be Treated:

| Right | | | | | | | | | | | | | | | Left |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 |

## Treatment:

☐ Consultation Only ☐ Consultation & Treatment

## Restorative Instructions:

☐ Place core build up
☐ Place post and build up
☐ Leave post space
☐ Place temporary

## Restorative Plan:

☐ Build up
☐ Crown
☐ To Be Determined

Special Instructions: _____

_____

_____

Our specialty office would like to welcome you for your appointment. Our staff is happy to help you with any questions you have prior to your visit. Please bring a copy of this referral slip with you as well as information needed to fill out a health history including the name and dose of prescribed medicines and your insurance information if applicable so we can help facilitate your payment for specialty services.