



**Endodontic Associates of Frisco**

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**Patient Information**

Date	
Patient Name	
Date of Birth	
Insurance Provider	
Member ID/SSN	
Home Phone	
Mobile Phone	

**Reason for Referral:**

- Patient has discomfort
- Previously opened
- Pulp exposure
- Periapical pathosis

**Treatment Required:**

- Root canal
- Retreatment

**Restoration Cemented:**

- Temporary
- Permanent

**Please Place:**

- IRM temp filling
- Composite
- Build-up

**Referring Office Information**

Dental Office	
Referring Doctor	
Office Phone	
Tooth Number	

**Remarks / Notes**
