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NEW ADDRESS

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www.rivercityendospokane.com

Patient Name: _____ DOB: _____

Insurance Provider: _____ Member ID: _____

Phone: (H) _____ (C) _____ (W) _____

Referring Doctor: _____ Date: _____

**TOOTH
TO BE
EVALUATED**

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

- Carious Pulp Exposure
- Sensitivity
- Spontaneous Pain
- Endodontic Treatment Required for Proper Restoration
- Endodontic Retreatment
- Endodontic Surgery
- Periapical Radiolucency Present
- Swelling Present
- Sinus Tract Present

RADIOGRAPHS

- Emailed
- Mailed
- Given to Patient

RESTORATIVE TREATMENT PLAN

- Place Temporary Restoration Only
- Place Post
- Place Final Restoration in Access Cavity

MISCELLANEOUS

- Please Call Me About This Case
 - Prior to Consult
 - Following Consult
- Crown/Bridge is Cemented:
 - Temporarily
 - Permanently
- Please Send Additional Referral Forms

SPECIAL INSTRUCTIONS

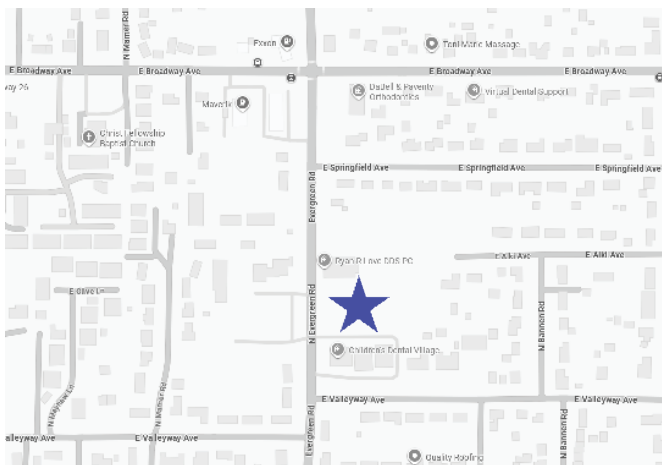
INSTRUCTIONS FOR PATIENTS

If you have dental insurance, please bring your insurance card to your appointment. Fees are payable at the time of treatment. All minors must be accompanied by a parent or legal guardian.



WE LOOK FORWARD TO YOUR VISIT WITH US!

Scan the QR code below for directions to our office.



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Fax 509.924.8892
Email info@rcendospokane.com