LANGLEY ENDODONTICS

DR. HOWARD BITTNER Inc. **DR. JASON CONN**

Certified Specialists in Endodontics

REFERRING DOCTOR

Dr. _____ Date _____

Dr. Ph _____

WE ARE REFERRING

Patient _____ Home Ph _____

Email _____ Work Ph _____

Appt Date _____ Cell Ph _____

Time _____

REASON FOR REFERRAL

Tooth Status

R 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 L
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

- ☐ Patient Has Pain/Swelling/Discomfort
- ☐ X-ray Reveal Apical Radiolucency
- ☐ Previous RCT Is Failing
- ☐ Endo Has Been Initiated
- ☐ Crown Cemented
- ☐ Temp ☐ Permanent

Treatment Requested

- ☐ Non-Surgical Endodontics
- ☐ Surgical Endodontics
- ☐ Evaluation Only

Close Access With

- ☐ Temp Restoration
- ☐ Composite
- ☐ Amalgam
- ☐ Leave Post Space

Comments:

_____

_____

_____

☐ Please Send More Referral Slips

Insurance Information & Map - Over ▸

303 - 6351 197th St
Langley BC V2Y 1X8

tel 604 532 4090
fax 604 532 4084

www.LangleyEndodontics.ca

Reception@LangleyEndodontics.ca

LANGLEY ENDODONTICS

DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ Birth Date _____
DAY MONTH YEAR

Employer _____

Insurance Co. _____

Group Plan# _____ Certificate# _____ Dep.# _____

Relationship To Policy Holder _____

Secondary Insurance Plan

Policy Holder's Name _____ Birth Date _____
DAY MONTH YEAR

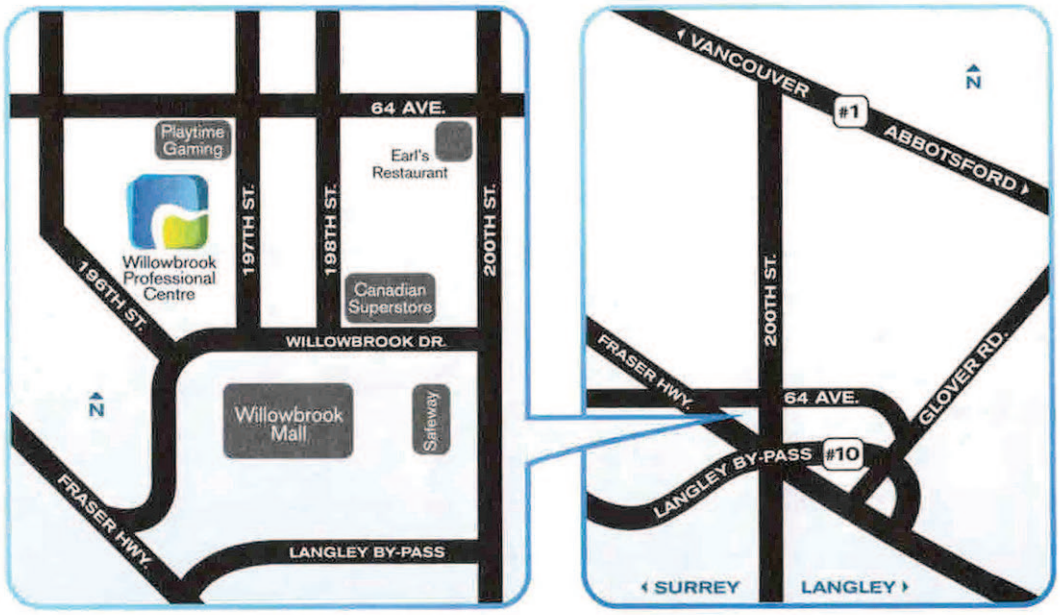
Employer _____

Insurance Co. _____

Group Plan# _____ Certificate# _____ Dep.# _____

Relationship To Policy Holder _____

DIRECTIONS



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