LONDON
ENDODONTICS

Dr. Victor Wagner, B.A., D.D.S, Cert. Endo.

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Referral from Dr. _____

Phone: _____ Contact Name: _____

REFERRING: _____

Phone: (H) _____ (W) _____

(C) _____ (O) _____

Date of birth: _____

Address: _____

Email: _____ Have we seen this patient before? ☐ Yes / ☐ No

Does the patient have insurance? ☐ Yes / ☐ No If yes, policy name: _____

Referral for tooth # / area: _____

Requesting: ☐ Consultation only / ☐ Consultation and treatment

Is this a retreatment? ☐ Yes / ☐ No Is there a pulp exposure? ☐ Yes / ☐ No

Has RCT already been started? ☐ Yes / ☐ No If yes, when? _____

A film is being: ☐ Emailed ☐ Mailed ☐ Pt will bring ☐ No film

Patient has been put on: ☐ Antibiotics ☐ Pain Medication ☐ No Meds

If meds have been prescribed, please list: _____

Level of discomfort? ☐ None ☐ Mild ☐ Moderate ☐ Severe

☐ Heat sensitive ☐ Cold sensitive ☐ Pressure sensitive

☐ Throbbing pain ☐ Facial Swelling ☐ Pain of unknown origin

Does patient require prophylactic antibiotics? ☐ Yes / ☐ No Does patient have a latex allergy? ☐ Yes / ☐ No

Additional comments: _____

_____

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_____

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