

BRASINGTON ENDODONTICS & MICROSURGERY, P.A.

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Greenville, SC 29601

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Patient Name: _____

Patient Home #: _____ Patient Cell #: _____

Referred by Dr.: _____ Dr. Phone: _____

Date of Referral: _____

Tooth # or Area of Concern: _____

Check all that apply

Evaluation Type:

- Evaluate and treat
- Evaluate only
- Call me before proceeding

Procedures Requested:

- Root Canal Therapy
- Non-surgical Retreatment
- Endodontic Surgery
- Build-up (White or Blue preferred?)
- Post Space

Reason for Visit:

- Patient has: Pain Swelling Sensitivity Sinus Tract
- X-Ray suggests: Pulp involvement Apical involvement
- Pulp or near pulp exposure
 - RCT required for restoration
 - Other: _____

Please list any recent dental treatment that has been performed in the area (temporary crowns, recent fillings, etc.) _____

Any other Management, Medical or Treatment Concerns: _____

- Please send additional referral forms

Patient Note: If you have dental insurance our office may contact you (or you may call us at 864-412-1007) to verify your insurance information before the appointment date. Please be sure to bring your insurance card to your appointment. Patients under the age of 18 years must be accompanied by a parent or guardian at the first visit. Please make arrangements for children not receiving care.

After completion of your root canal therapy, you should contact your referring dentist immediately to schedule your final restoration.

Please call us if you have any questions or concerns.

