Endodontic Specialists of Colorado, P.C.
where state-of-the-art expertise and personalized care meet

ENDODONTIC
FAX REFERRAL FORM
Fax: 719.599.8599

CONFIDENTIAL

Introducing:_____ **Date:**_____

Patient's Date of Birth: _____/_____/_____ **SS#:** _____/_____/_____

Patient's Home #:_____ **Work #:**_____ **Cell#:** _____

Insured Name_____ **DOB:** _____/_____/_____

SS#:_____/_____/_____ **Employer:**_____

DENTAL INFORMATION ~

Dental Plan:_____ **Group #:** _____

Tooth #: _____ **Prev RCT on this tooth? (Y/N):** _____ **Post:**_____

Symptoms: **Hot**_____ **Cold**_____ **Pressure**_____ **Other**_____

APPOINTMENT INFORMATION ~

Appt. for: Consultation Only: _____ **Consultation & Treatment:** _____

I Plan To Crown This Tooth:_____ **Prepare Post Space:**_____

Additional Comments/Requests:_____

_____

_____

NEXT STEPS ~

_____ **Please Call Patient & Schedule**

_____ **Patient Will Be Calling To Schedule Within One Week**

THANK YOU! We truly appreciate your continued referrals! We promise to treat your referrals with state-of-the-art expertise and personalized care. Please call us if you have any questions.

ENDODONTIC SPECIALISTS OF COLORADO
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