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Yogesh Patel, DDS

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Referral Form

Date: _____

Patient Name: _____

Date of Birth: _____

Insurance Name: _____

Member ID/SS#: _____

Home Phone: _____

Mobile Phone: _____

Home Dental Office: _____

Office Phone: _____

Referring Doctor Name: _____

Tooth #: _____

Remarks / Notes:

REASON FOR REFERRAL:

- patient has discomfort
- previously opened
- pulp exposure
- periapical pathosis

TREATMENT REQUIRED:

- root canal
- retreat root canal

RESTORATION CEMENTED:

- temporary
- permanent

PLEASE PLACE:

- IRM temp filling
- composite
- build-up