CASCADE ENDODONTIC GROUP

Daniel Bitner DMD
Patricia Paparcuri DMD
1590 NE Williamson Blvd
Bend, Oregon 97701
www.CascadeEndodontics.com

Patient Referral Form

Patient Name: _____ DOB: _____

Patient Phone Number: _____ Date: _____

Referred by Dr. _____

Radiographs (please circle): Sent with patient Emailed None Sent

Please do not take pain medications within six hours of your exam appointment.

PLEASE PERFORM THE FOLLOWING SERVICE:

Tooth #: _____

- ☐ Examination and Consultation Only
- ☐ Diagnose and Treat as indicated
- ☐ Endodontic Retreatment or Surgery
- ☐ Other: _____

_____

TREATMENT CONSIDERATIONS:

- ☐ Previous Endodontic Treatment Date: _____
- ☐ Pulp Exposure
- ☐ History of Trauma

Bridge/Crown Cemented:

- ☐ With Temporary
- ☐ Permanently

Restore Access:

- ☐ With Temporary
- ☐ Permanently
- ☐ Leave Post Space

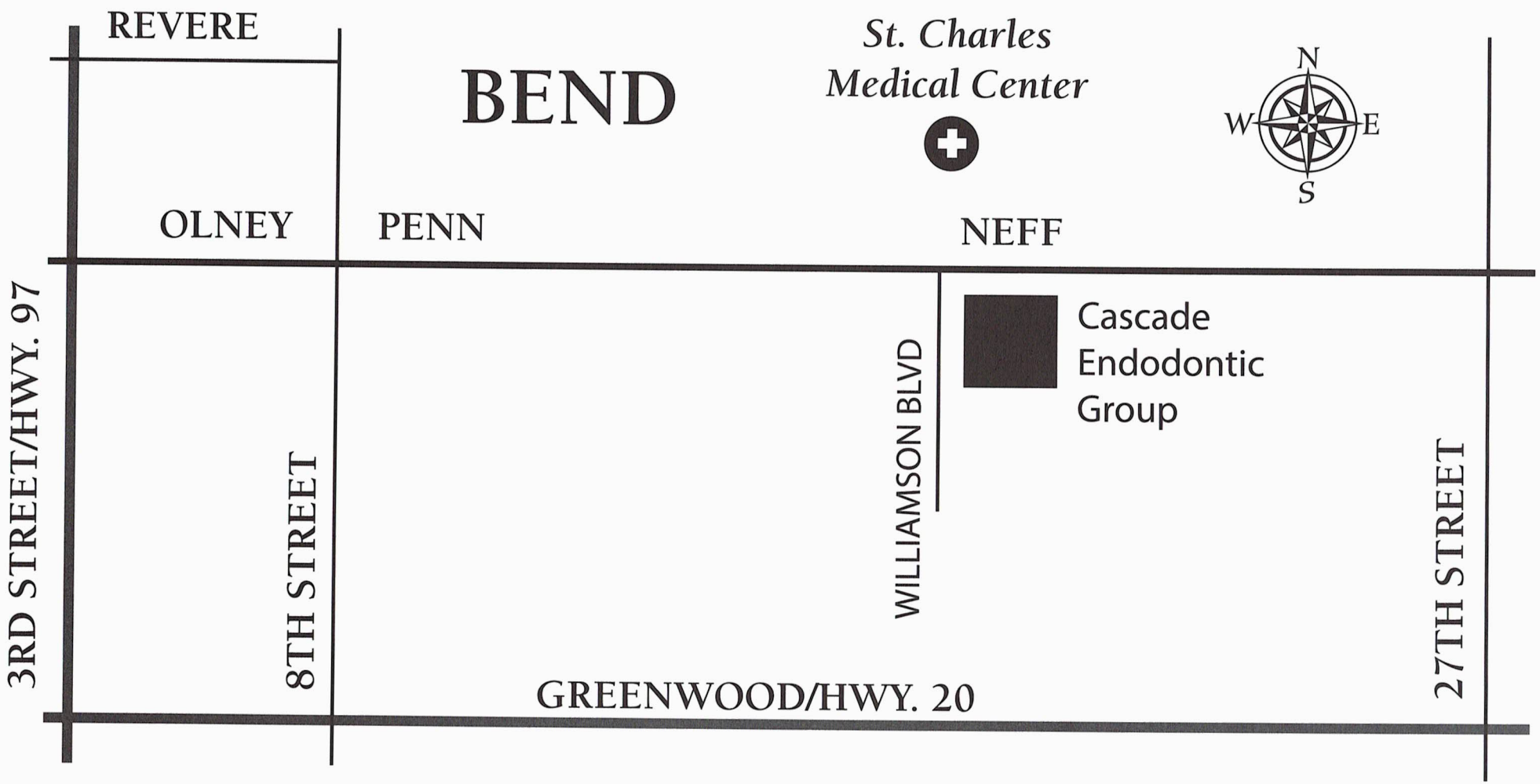
Dental Insurance Information

Primary Insurance:
Insured: _____
Insured's DOB: _____
Carrier: _____
Group #: _____
ID/SS #: _____

Secondary Insurance:
Insured: _____
Insured's DOB: _____
Carrier: _____
Group #: _____
ID/SS #: _____

Notes: _____

541-388-1500
541-388-6995 (fax)
www.CascadeEndodontics.com



24 hr notice required for cancellation of appointments.

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