Richmond Endodontic Associates

☐Dr. Raymond Greenfeld ☐Dr. Jeffrey Coil Inc.
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CERTIFIED SPECIALISTS IN ENDODONTICS

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Introducing_____ DOB _____ Remarks:

Patient phone #:(H)_____(C)_____

Insurance: ☐N ☐Y (please provide details at the back of the form)

☐Please call patient ☐Patient will call

☐Appointment already scheduled on

_____

Tooth/Area of concern

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Tooth #_____

Referral Request

☐Consult only
☐Consult & treat as necessary
☐Call to discuss first
☐Prophylactic RCT
☐CBCT
☐Upper /☐Lower jaw
☐Tooth #_____
☐Panoramic

Tooth status

☐Pain ☐Swelling ☐Fistula ☐Trauma
☐RCT started, please complete
☐Previously treated☐our /☐other office
_____☐months /☐years ago
☐Recent filling / crown
_____☐months /☐years ago
☐Crown to be placed / replaced

After RCT

Please restore the access
☐Temporary
☐Permanent
☐Leave post space

Report

☐Email
☐Paper

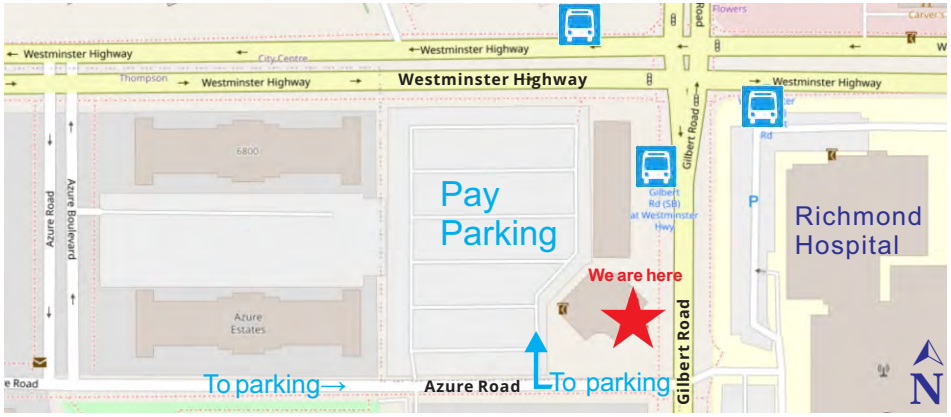
Referred by Dr._____

Signature:_____

Date:_____(Y)_____(M)_____(D)

Office Phone #:_____

☐Please send more referral pads.
Fillable PDF referral form available at www.endobc.com



Our office is located on the 8th floor of Richmond Health Sciences Center, right across the street from Richmond Hospital. Pay parking spaces are accessible **via Azure Road**. Bus 401 and 407 have stops very close to our building.

Please bring the following to your first appointment **if available**:

— List of medications and allergies;
— Dental insurance information;
— Referral note/ radiograph/ CBCT scan

Dental Insurance Information:

Primary _____

Provider Policy# ID#

Secondary_____

Provider Policy# ID#