Blue Ridge Endodontics

SPECIALIST MEMBER

Robin E. Bagby, DDS
Michael J. Mayerchak, DMD

Today's Date _____

This is to introduce _____ _____ _____
FIRST NAME LAST NAME (patient daytime phone #)

☐ Patient scheduled for an appointment in your office _____

at _____ ☐ am ☐ pm

Doctor's Recommendation for Referral

- ☐ Endodontic Treatment
- ☐ Consultation and Diagnosis (treat as needed)
- ☐ Microsurgery/Apicoectomy
- ☐ Emergency Treatment
- ☐ Retreatment
- ☐ CBCT Imaging/Evaluation
- ☐ Conscious Sedation
- ☐ Consultation Only

Please Circle Tooth or Teeth Number

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R																L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Prepare Post Room ☐ Yes ☐ No

Restorative, Periodontal Treatment and /or Temporary Filling Preference. Comments:

Referred by Dr. _____

Please Call me at _____

Please email or fax this referral form to us:

email doctors@blueridgeendo.com **fax** (540) 772-0716

Please also give the patient a copy to bring for their appointment.
We will verify all insurance plans for your patients.
We are committed to professional and compassionate care.

Main Office
4102 Electric Road
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Satellite Office
104 S. Jefferson Street
Lexington, VA 24450

(540) 772-9515 blueridgeendo.com