Unique Expertise.
Unparalleled Patient Care.

Sandy Wang, DDS, MS
Diplomate, American Board of Endodontics (Board Certified)

Referral Form

Date: _____

Patient Name: _____

Phone: _____

ENDODONTIC CONSIDERATIONS

Please Place a Check on the Involved Teeth:

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

Reason for Referral:

- ☐ Patient has pain, swelling, sensitivity
- ☐ Medical health alert
- ☐ Tooth has been previously opened
- ☐ Other _____

Treatment Requested

- ☐ Diagnosis only
- ☐ Treatment
- ☐ Repair Access with
  - ☐ Composite
  - ☐ Alloy
  - ☐ Cotton / Cavit / Temporary
- ☐ Place post and core
- ☐ Prepare post space only
- ☐ Other _____

Comments: _____

_____

_____

PLEASE EMAIL COMPLETED FORM TO INFO@FM-ENDO.COM

Contact Info

2560 Central Park Ave, Suite 128
Flower Mound, Texas, 75028

972.539.1988

info@fm-endo.com

www.fm-endo.com

Appointment Information

Date:

Day:

Time:

Referred By: