LAKESIDE DENTAL CARE

ENDO REFERRAL FORM

2400 Veterans Blvd. Suit 210 • Kenner, LA 70062
Phone: (504) 833-3200 • Fax: (504) 833-0813

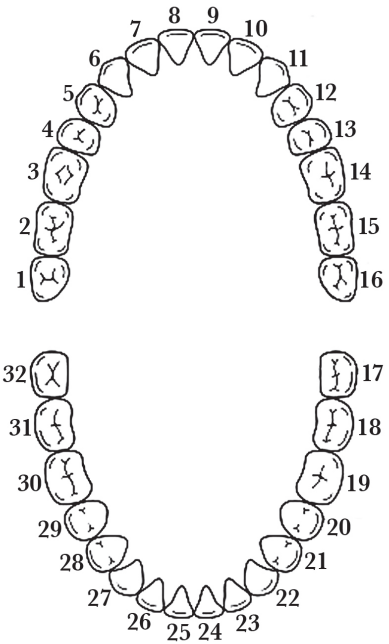
RÉGINE DYER, DDS, ENDODONTIST

PATIENT INFORMATION

Patient's Name: _____ Cell Phone: _____

Insurance Company: _____ ID Number: _____

Please send and complete referral form completed with all the patient and insurance data. Scan and email to **rpena@amdpi.com** or **nmark@amdpi.com** or fax to **(504) 833-0813.**



Tooth # _____

REFERRING GENERAL DENTIST INFORMATION

If you have digital X-Rays, please email them to **rpena@amdpi.com** or **nmark@amdpi.com**

DDS Name: _____

Phone Number: _____

REASON FOR REFERRAL

- ❒ Consultation Only
- ❒ nsRCT
- ❒ Re-Treatment
- ❒ Apicoectomy

RESTORATIVE REQUEST

- ❒ Temporary Filling
- ❒ Make post space
- ❒ Composite core Build-up
- ❒ Post and core Build-up

ADDITIONAL COMMENTS

❒ Call referral about this case

_____

_____

SIGNATURES

_____ _____

Referring DDS Signature Date