ENDODONTICS
REFERRAL FORM

ADVANCED DENTAL

ADVANCED DENTAL
(718) 292-8988
www.advancedbronxdental.com
www.lohuddental.com

☐ BRONX: (718) 292-8988
237 Willis Avenue, Bronx, NY 10454
Fax: (917) 792-7979

☐ WESTCHESTER: (914) 874-5757
130 Garth Road, Scarsdale, NY 10583

Most Insurances & Unions accepted as full or partial payment.

Date: _____/_____/_____

Patient Name: _____D.O.B _____/_____/_____

Patient Insurance:_____Patient ID:_____

Ref. Doctor Name: _____ Doctor Phone: _____

REFERRAL DUE TO:

_____

- ☐ Consultation
- ☐ Root Canal Therapy
- ☐ Retreatment
- ☐ Apicoectomy
- ☐ Post Space
- ☐ Biopsy
- ☐ Hemisection
- ☐ Radiographs Enclosed

Needed																Needed
Existing																Existing
R	1	2	3	A/4	B/5	C/6	D/7	E/8	F/9	G/10	H/11	I/12	J/13	14	15	16
	32	31	30	T/29	S/28	R/27	Q/26	P/25	O/24	N/23	M/22	L21	K/20	19	18	17
Existing																Existing
Needed																Needed

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