ENDODONTIC ASSOCIATES
DENTAL GROUP

Your name: _____

Your e-mail address: _____

Occasionally when treating your patients, we recognize the need to obtain a professional opinion from a dental specialist outside the scope of endodontics. It is our policy to contact you prior to referring your patient to another specialist; however, in the event that you are unreachable, we would appreciate having your preferences on file.

Please complete this form and submit below with your preferences in the aforementioned situation. Your preferences will be noted, and honored whenever possible. This information, will of course, be kept confidential. **We will always attempt contacting you prior to referring your patient to a dental specialist**; however, this will ensure that your patients are referred within the realm of your specification if we are unable to reach you.

Please complete the following information:

☐ I do not have a preference, please refer my patient as you deem appropriate.

☐ Please do not refer my patients elsewhere except in the event of an emergency.

☐ Please refer my patients as noted below.

Dental Specialist Preferences:

Periodontics

Group or Specialist: _____ Phone #: _____

Group or Specialist: _____ Phone #: _____

Prosthodontics

Group or Specialist: _____ Phone #: _____

Group or Specialist: _____ Phone #: _____

Oral Surgery

Group or Specialist: _____ Phone #: _____

Group or Specialist: _____ Phone #: _____

Thank you for your assistance!

Sincerely,
Endodontic Associates Dental Group

SUBMIT BY EMAIL PRINT FORM