ENDODONTIC ASSOCIATES
DENTAL GROUP

Dentist name: _____

Email 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 be kept confidential. **We will always attempt to contact 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 if you are unable to reach me.

☐ Please contact me on my cell phone after hours. Cell #: _____

Dental Specialist Preferences:

Oral Surgery

Group or Specialist: _____ Phone #: _____

Group or Specialist: _____ Phone #: _____

Periodontics

Group or Specialist: _____ Phone #: _____

Group or Specialist: _____ Phone #: _____

Myofascial Pain Specialist

Group or Specialist: _____ Phone #: _____

Group or Specialist: _____ Phone #: _____

Thank you for your input. We sincerely appreciate our partnership with you!

Endodontic Associates Dental Group

SUBMIT BY EMAIL PRINT FORM