



East Coast Endodontics

PRACTICE LIMITED TO ENDODONTICS

Referral

Roderick M. MacIntyre, D.M.D., M.S., P.A.

912 S. Ridgewood Ave., Suite C
Daytona Beach, FL 32114
(386) 252-0858 Fax: (386) 253-7004

INTRODUCING

Patient Name _____

Referred by Dr. _____

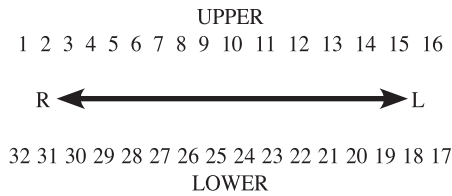
Phone _____ Date _____

Reason for Referral: Endodontic Evaluation

Endodontic Therapy

Tooth # / Comments

Please circle teeth for endo construction



Post Space Desired SBE Prophylaxis Required

X-ray enclosed Please return x-rays

Appointment Date _____ Time: _____

Check box if you would like more referral slips

We inform your patient that the root canal therapy has not been completed until the tooth has been properly restored. Therefore, we instruct the patient to return to you for a final restoration after sealing the tooth.

