SOUTH OKANAGAN ENDODONTICS

Dr. Rene Buttar
Endodontist
B.Sc., D.M.D., M.Sc., Dip. Endo, FRCD(C)

PATIENT INFORMATION

Name: _____ D.O.B (DD/MM/YY): _____

Gender: ❑ F ❑ M Email: _____

Address: _____

City: _____ Postal Code: _____

Phone: (H) _____ (W) _____

Significant Medical History: ❑ Prophylactic Antibiotics Required

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Secondary Insurance Carrier: _____

Subscriber: _____ Subscriber: _____

D.O.B (DD/MM/YY): _____ D.O.B (DD/MM/YY): _____

Group Policy #: _____ Group Policy #: _____

ID #: _____ ID #: _____

REASON FOR REFERRAL

Tooth Requiring Examination/Treatment: _____

Radiographs: ❑ sent with patient ❑ sent by mail ❑ sent by email ❑ none

Reason for Referral
- ❑ Consult only
- ❑ Consult and Treatment, as necessary
- ❑ RCT initiated, please complete
- ❑ Retreatment or Apical Surgery
- ❑ Other:

Existing Restoration
- ❑ Tooth +/- Composite/Amalgam
- ❑ Permanent Crown (permanent cement)
- ❑ Permanent Crown (temporary cement)
- ❑ Temporary Crown
- ❑ Permanent Crown to be replaced

Requested Coronal Restoration
- ❑ Temporary Restoration
  - ❑ Post space
- ❑ Permanent Core and Restoration
  - ❑ Post
- ❑ Other:

Urgency
- ❑ Immediate Treatment Required
- ❑ Schedule at Convenience

Referred by Dr: _____ Phone: _____ Email: _____
(Please Print)

Signature: _____

Comments:

South Okanagan
DENTAL SPECIALISTS

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