Greater Washington Endodontics
Patient Referral Form

3801 N. Fairfax Dr., Suite 40
Arlington, VA 22203
Phone (703) 527-6885
Fax (703) 527-6876

9673 Main Street, Unit D
Fairfax, VA 22031
Phone (703) 534-4884
Fax (703) 534-3447

11710 Plaza America Dr., Suite 150
Reston, VA 20190
Phone (703) 481-2096
Fax (703) 481-2074

12701 Marblestone Dr. Suite, 180
Woodbridge, VA 22192
Phone (571) 298-2000
Fax (571) 298-2004

Introducing _____for endodontic treatment consideration.

Molars:	1 ____ 2____ 3____ 32____ 31____ 30 _____
	14____15____16____19____18____17 _____
Bicuspids:	4____5____29____28 _____
	12____13____21____20 _____
Anteriors:	6____7____8____9____10____11_____
	27____26____25____24____23____22_____

_____Patient has pain or swelling or sensitivity, please evaluate
_____Patient has pain or swelling
_____Proper restoration
_____Tooth has been opened
_____Pulp was exposed
_____Radiograph reveals pathology
_____Post space requested

Comments:
_____
_____
_____
_____

Referring Dr: _____ Phone# _____
Email: _____

How would you like to be contacted about your patient? Phone _____

Email _____
Your patient will be instructed to return to you, their referring dentist, for final restoration.