HOLLINGER DENTAL GROUP

ENDODONTIST REFERRAL FORM-**DR. ALI TAHERIAN**

100 Waterloo Rd. ▪ Timmins, ON P4N 4X5

Phone 705-267-1020 ▪ Fax 705-268-8350

PATIENT INFORMATION DATE:________________

PATIENTS'S NAME: ____________________________________ DOB: ____________________

TELEPHONE NUMBER: (H): ____________________________ (M): ____________________________

ADDRESS:____

PATIENT EMAIL:_________________________ REFERRING DENTIST: _________________________

INSURANCE DETAILS

INSURANCE COMPANY: ____________________ INSURANCE HOLDER:_________________________

GROUP#:____________ CERTIFICATE#:____________________ DOB:________________________

2nd INSURANCE:___________________________ INSURANCE HOLDER:________________________

GROUP#:____________ CERTIFICATE#:_____________________ DOB:________________________

Radiographs Date of Recent PA: ______________

☐ Enclosed

☐ Emailed

Tooth/Teeth:	**1**	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	**2**
(please circle)	RIGHT			LEFT
	4	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	**3**

Reason for Referral: ____

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Treatment Administered Prior to Referral:

- ☐ Endodontic treatment has been initiated
- ☐ Crown/Bridge cemented Date: __________
- ☐ Occlusal adjustment
- ☐ Rx antibiotic _____________________
- ☐ Previous root canal treatment When: ___________
- ☐ Incision and drainage
- ☐ Rx analgesic

- ☐ Post Space required Which canals?

- ☐ Pre medication required

Pertinent Medical History:

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Please include recent PA and email referral to specialists@hollingerdental.ca