



Dr. Tamara Biary Board-Certified Endodontist

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Patient Name _____ Patient Phone Number _____ Date _____

Referring Doctor _____ Referring Doctor Phone Number _____

Appointment Status: Date _____ Time _____ Or Patient Will Call to Schedule

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Reason for Referral

- Consultation: _____
- Root Canal Therapy: # _____
- Endodontic Retreatment: # _____
- Endodontic Surgery: # _____

Diagnostic Information

- Percussion? Y/N Thermal? Y/N
- Sinus Tract: # _____
- Endodontic Care to Facilitate Restorative Care?

If Antibiotic started - Date & Regimen: _____

Comments: _____

Restoration Considerations

- Post Space Requested? Y/N
- Sponge and Cavit Temp? Y/N
- Complete Core Buildup? Y/N

**Please send recent radiographs.
PAs & BWs, if possible.**

Exposure Date: _____

Please have your General Dentist complete this form and email it to our office at frontdesk@beverlyfarmsdental.com. If you do not have a general dentist, please call our office.

Scan for information on our providers and services:

