ENDODONTIC
PATIENT REFERRAL FORM

Patient Information

Name: ____

Birth date: ________________________ Gender: ☐ M ☐ F

Address: ____

____

Phone: ____

Dental Ins: ____

Medical Ins: _______________________________________

ID #: ____

Preferred Surgeon

☐ First available

☐ Dr. Vasiliki Kytridou

☐ Dr. Polymnia Tsotsis

Referred by:

Name: ____

Facility: ______________________________________

Phone: ____

Radiographs:

___Enclosed ___Patient will bring ___None provided ___Will be sent ___On AxiUm

To transfer patient records and radiographs electronically, please visit the following URL: https://sdm.siue.edu/xraydropboxfp/uploadxrays.php.

Please include your office name/phone number, patient name/date of birth, and date of radiographs.

Tooth #	Eval	Treat	Retreat	Post Space	Findings/Treatment Advised:
______	_____	_____	_______	_________	____
______	_____	_____	_______	_________	____
______	_____	_____	_______	_________	____
______	_____	_____	_______	_________	____

☐ Tooth (teeth) appears to be restorable.

☐ Patient has been advised that the tooth will require a final restoration.

Signature: ____ Date: _____________________

- Scheduled patients will **not** be seen without a written referral from their dentist.
- Referrals are valid for four (4) months from the date written above. After four (4) months, a new referral will be needed.