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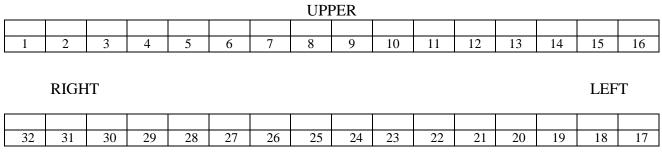
## **REFERRAL FORM**

PATIENT INFORMATION		
Date:		
Patient Name:		
Home/ Cell Phone:		
Office Phone:		
	REFERRING DOCTOR INFORMATION	
Referred By:		
Phone:		
Email:		

## PLEASE MARK THE FOLLOWING TREATMENT

Root Canal	Leave Post Space
Retreatment	Place Post and Core
Place Composite Core	Please call patient to arrange appointment
Consultation & Diagnosis	Patient will call you to arrange appointment
Apicoectomy / Retrograde	Please send more referral pads
Pulpal Exposure	Please call me

## PLEASE MARK TEETH OR AREA TO BE EVAULATED



LOWER

REFERRING DOCTORS - To ensure a smooth patient transition, please have your front desk staff call to schedule the patient's appointment, fax the referral form to 940-228-4148 or email this referral form to info@WichitaFallsEndo.com.