Kevin S. Welinsky D.D.S.
8600 Lasalle Road
Ste 507
Towson, MD 21286
P:410-321-8480
F:410-321-8482
Email:wdctowson@gmail.com

Endodontics Referral

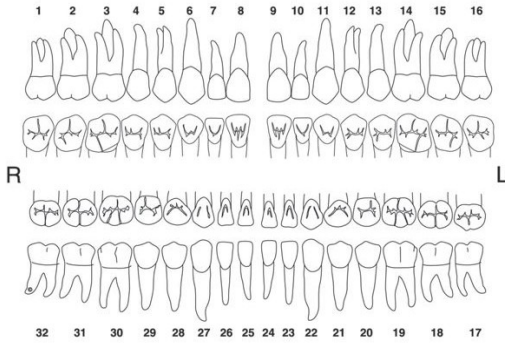
Patient Name: _____ Date of birth: _____

Phone: _____ Parent's Name:_____

Patient Insurance Information: _____

Reason for referral:

☐ Consultation
☐ Root Canal Treatment
☐ Root Canal Re-Treatment
☐ Apical Surgery
☐ Vital Pulp Therapy, Revascularization, or Apexification
☐ Other _____



Medical and Dental History:

Tooth number or area: _____

☐ Negative
☐ Significant
☐ Patient may require nitrous oxide or oral sedation
☐ Special needs

Restorability and periodontal status:

☐ Tooth has been evaluated for restorability and periodontal support
☐ Crown lengthening may be needed after RCT
☐ Post space requested
☐ Patient is to return to referring dentist for all restorative and periodontal therapy

Notes:_____

_____

Referring Doctor information:

☐ X-rays Given to Patient ☐ X-rays mailed/E-mailed ☐ Needs X-rays

Referring Doctor: Kevin S. Welinsky DDS Phone: 410-321-8480

Email address: wdctowson@gmail.com Date: _____