



Date of Referral _____

Patient's Name _____ DOB _____

Parent/Legal Guardian's Name (If patient is a minor) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Scheduling Instructions (Check only one)

- Patient will contact Dr. Lavin's office
- Dr. Lavin's office to contact patient
- Referring office has scheduled appointment for _____
(Date and time)

Referred by Dr. _____ Phone _____

Referring DDS Signature _____

Please circle teeth or site to be evaluated

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

Radiographs

- To be taken
- Attached
- Mailed
- Emailed to referral@lavinendo.com

Endodontic Considerations

- Patient needs to be pre-medicated
- Patient has pain, swelling or sensitivity
- Radiograph revealed radiolucency
- Pulp was exposed
- Unable to locate canals
- Previous root canal treatment

Treatment Requested

- Consultation
- Root canal treatment
- Retreatment
- Periapical surgery
- Other _____

Comments _____



MARSHALL T. LAVIN DDS, PC
ENDODONTIC SPECIALIST

Appointment

Day _____ Date _____ Time _____

Instructions to the Patient

1. Minors must be accompanied by a parent or legal guardian at the first appointment.
2. Endodontic therapy is usually completed in one or two separate appointments.
3. Fees are payable at the time of treatment.
4. If you have dental insurance coverage, please bring your insurance card(s) and/or claim form to your appointment.

Location

1710 S Southeastern Ave, Suite 100
Sioux Falls, SD 57103

Directions

Take the 26th Street exit off I-229. Go right (east) on 26th Street to the stop light. At the light, go left (north) on Southeastern Avenue. Take the first right on to River Ridge Place. Our office overlooks Southeastern Avenue, and parking is available on the west side of the building.

