Marshall T. Lavin
ENDODONTICS

Referral Information

Patient's Name _____ DOB _____

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

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Patient Insurance Information

Policy Holder Name _____ Insurance Name _____

Group Number _____ ID Number _____

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 DD Signature _____ Date of Referral _____

Please circle teeth or site to be evaluated

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	L
	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
- ☐ Other _____

Comments _____

_____

_____

3400 E. 26TH ST. SIOUX FALLS, SD 57103

P (605) 334–7979 | **F** (605) 334-2275 | LAVIN**ENDO**.COM

Updated 07-26-2021

Marshall T. Lavin
ENDODONTICS

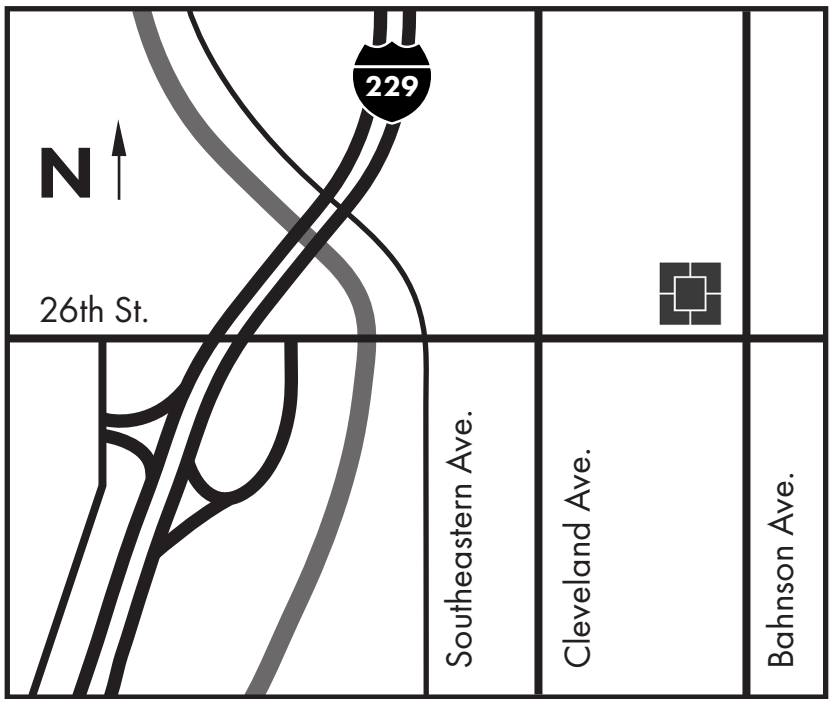
Referral Information

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
3400 E. 26th St.
Sioux Falls, SD 57103

Directions
1 mile east of I-229
Across the street from Apple Tree Learning Center

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