Endodontists

Amro Elkhatieb B.D.S, D.D.S, M.S.D.
Christina Cho D.M.D.
Steven Williams D.M.D.

Periodontists

Edwin Tsang, D.M.D., M.S.D
Diplomate of the American Board of Periodontology
Evan Santiago, D.D.S., M.S.D
Diplomate of the American Board of Periodontology
Harley Williams D.M.D.

999 E Stanley Blvd., Suite C • Livermore, CA 94550 (925) 371-0300
www.rootsandgums.com • staff@rootsandgums.com

PATIENT INFORMATION

Today's Date ____________________

First Name ____________________ Last Name ____________________ Date of Birth ____________________ Sex ☐ M ☐ F

Name of Insurance Company ____________________ Insurance ID # ____________________

Subscriber Name: ____________________ Date of Birth ____________________ Insurance Amount Pending From Your Office ____________________

Contact Telephone ____________________ Contact Email Address ____________________

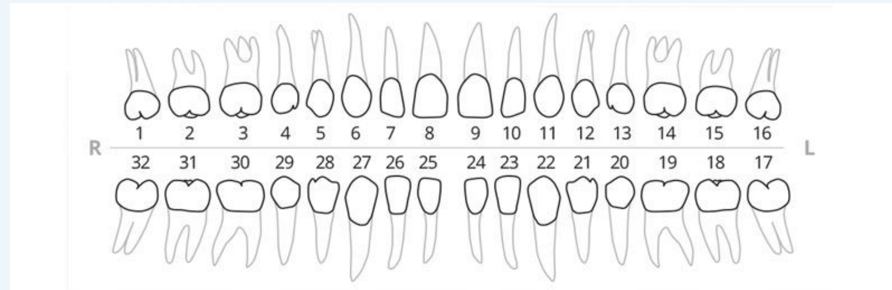
☐ Patient will call for appointment ☐ Please call patient

REFERRING DOCTOR'S INFORMATION

Referred By ____________________ Office Telephone ____________________

Email Address ____________________

PLEASE MARK TEETH / AREA TO BE TREATED



RADIOGRAPHS

☐ Emailed to staff@rootsandgums.com
☐ Please take radiographs as necessary
☐ Copy of CBCT given to patient

PERIODONTAL REFERRAL

☐ Dental Implants (Single / Multiple / All-On-X)
☐ Periodontal Disease
☐ Gum Graft / Recession
☐ Extract
☐ Ridge Augmentation / Sinus Lift
☐ Crown Lengthening (Functional / Cosmetic)
☐ Infected or Failing Implant
☐ Frenectomy
☐ Biopsy
☐ Other ____________________

ENDODONTIC REFERRAL

Tooth Presents With:

☐ Pain: Cold / Hot / Biting
☐ Swelling
☐ History of Trauma
☐ Crack or Fracture
☐ Root Resorption

Reason For Referral:

☐ Consultation only
☐ Root Canal Treatment
☐ Retreatment
☐ Apicoectomy

Restorative Preference:

☐ Temporary Filling
☐ Leave Post Space
☐ Build Up
☐ Post and Build Up

CASE NOTES:

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