Endodontic Associates of Central Texas

410 E Central Texas Expy. Harker Heights, TX 76548
254.554.3636 254.519.3638
Email Form/X-rays: office@eacentex.com

Referral Form

Date ________________

Referring Doctor's Name ______________________ Office Phone # ________________

Tooth # ______________ Patient in Pain : ☐ Yes ☐ No (Check one)

Step 1: Referral For

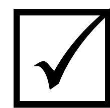
- ☐ Asymptomatic
- ☐ Thermal Sensitivity
- ☐ Biting Pain
- ☐ Spontaneous Pain
- ☐ Swelling
- ☐ Radiographic Findings
- ☐ Pulp Exposure
- ☐ Deep Decay
- ☐ Cracked Tooth
- ☐ Trauma
- ☐ Restoration
- ☐ Previous Root Canal

Step 2: Service Requested

- ☐ Consultation
- ☐ Initial Root Canal Therapy
- ☐ Retreatment of Root Canal
- ☐ Endodontic Root-End Surgery
- ☐ Internal Bleaching

Step 3: Desired Restoration

- ☐ Temporary Filling
- ☐ Permanent Filling
- ☐ Post & Core
- ☐ Leave Post Space



Please check all that apply

Dr. Care Notes:

Patient Information :

Name ______________________ Date of Birth ______________________

Preferred Phone ______________________

Insurance Information :

Subsriber's Name ______________________ Date of Birth ________________

Subscriber's ID or SS # ______________________ Ins. Phone ________________

Name of Insurance ____

Download this form: www.eacentex.com/referring-doctors/