ENDOSURE
SPECIALISTS IN SAVING TEETH

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ENDODONTIC REFERRAL

Please fill in, and either scan or save as a PDF and email back to us at reception@endo.co.nz

( ) **DR. DAVID PARKINS** Endodontist
BDS (Otago), Cert. Endo (Dallas, Texas)

( ) **DR. NINA SCOTT** Endodontist
BDS DClinDent Endo (Otago)

Dentists Details

Dr: _____

Address: _____ Post Code: _____

Phone Work: _____ Mobile: _____

Email: _____

Patients Details

Name: _____

Address: _____ Post Code: _____

Phone Work: _____ Mobile: _____

Phone Home: _____ DOB: _____/_____/_____

Email: _____

Tooth Number/s: _____

ACC Details Claim #: _____ DOA: _____/_____/_____

Medical History:

Reason for Referral:

Contact our Patient

Consultation Requested: ( )

Treatment Required: ( )

Please send Radiographs or Photographs as **jpeg files** to aid in diagnosis and treatment planning.

Your films, if not digital, will be scanned and returned.

Signature: _____ Date: _____/_____/_____