PLEASE BRING THIS REFERRAL TO YOUR APPOINTMENT

TRI - COUNTY ENDODONTICS

ROOT CANAL SPECIALISTS

Website: www.drkotz.com

Jeffrey C. Kotz, DMD
846 St. Andrews Blvd., Suite C
Charleston, SC 29407

Email: info@drkotz.com
Telephone: (843) 225-9002
Fax: (843) 225-6995

Practice Limited to Endodontics

_____ 20 ____

This will introduce:

Patient name _____

Patient number _____

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

- ❑ Patient has a toothache – Please evaluate
- ❑ Pulp was exposed
- ❑ X-ray revealed pulpal involvement
- ❑ X-ray revealed radiolucency
- ❑ Post space needed
- ❑ Evaluate for Microsurgery (Apicoectomy)

Comments _____

Appointment Time _____

Referred by Dr. _____ Phone _____

PATIENTS: PLEASE REGISTER AT DRKOTZ.COM/REGISTER TO EXPEDITE THE REFERRAL PROCESS

PATIENT WILL BE RETURNED TO REFERRING DENTIST FOR FINAL RESTORATION