

SUMMIT ENDODONTICS

Meghan E. Hatfield, D.M.D.

Board-Certified Endodontist

Practice Limited to Endodontics • Specialty #6070

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PATIENT REFERRAL

Date: _____

Referring Doctor: _____

Patient Name: _____

Tooth Number / Treatment Area: _____

TREATMENT INDICATED

☐ Root Canal Treatment | ☐ Retreatment | ☐ Apicoectomy

Post Space Needed?

☐ Yes ☐ No ☐ Undetermined

☐ Have any recent radiographs been taken?

If yes, please email the X-rays to: ***SummitNJEndo@gmail.com***

ADDITIONAL NOTES

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Thank you for your referral!