PATIENT REFERRAL

Please complete this slip for patient to bring to their appointment.

GentleWave® PROCEDURE

Scan to hear from real GentleWave® patients

PATIENT NAME _____

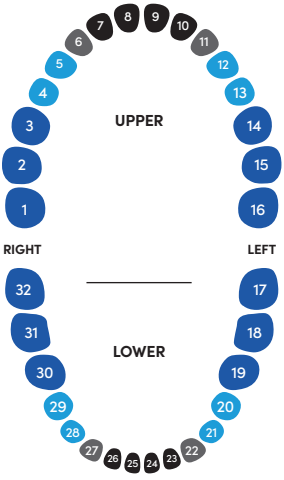
PATIENT PHONE NUMBER _____

PATIENT BIRTHDATE _____

REFERRING DOCTOR _____

APPOINTMENT DATE _____ **TIME** _____

TOOTH NUMBER



TYPE OF REFERRAL

- ☐ Endodontic consultation / treat as necessary
- ☐ Surgical evaluation
- ☐ Retreatment

RESTORATIVE REQUESTS

- ☐ Temporary restoration
- ☐ Post space
- ☐ Permanent restoration
- ☐ Post and buildup

DIAGNOSIS (IF KNOWN) _____

NOTES _____

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