REFERRAL FORM

South County
12818 Tesson Ferry Rd, Ste 202
St. Louis, MO 63128

(314) 994-3737

Creve Coeur
522 N. New Ballas Rd, Ste 382
St. Louis, MO 63141

www.endo-specialists.com

Patient Last Name *(Required)*	**First Name** *(Required)*	**Cell Phone**	**Doctor**
			☐ Wedding ☐ Eckstaine
Patient Date of Birth *(Required)*	**SS#**	**Email**	

Patient Address *(Street, City, State, Zip)*

General Dentist and/or Referring Doctor *(Last, First, Required)*	**Practice Name**

Primary Insurance:			**Secondary Insurance:**		
Phone *(Insurance)*			**Phone *(Insurance)***		
Policy Holder's Name	**Policy Holder DOB**		**Policy Holder's Name**	**Policy Holder DOB**	
Social Security Number			**Social Security Number**		
Subscriber /Member ID	**Group Number**		**Subscriber /Member ID**	**Group Number**	
☐ INW ☐ OON	Deductible $		☐ INW ☐ OON	Deductible $	
Max $	Remaining $		Max $	Remaining $	
Endo %	Major %	Basic %	Endo %	Major %	Basic %
Discount %			Discount %		

Indicate Tooth Number

RIGHT	**UPPER**	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
	LOWER	☐ 31	☐ 30	☐ 29	☐ 28	☐ 27	☐ 26	☐ 25
LEFT	**UPPER**	☐ 9	☐ 10	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15
	LOWER	☐ 24	☐ 23	☐ 22	☐ 21	☐ 20	☐ 19	☐ 18

SYMPTOMS

- ☐ PAIN - Waking up
- ☐ PAIN - Biting
- ☐ Intermittent
- ☐ Constant
- ☐ Swelling
- ☐ Hot/Cold Sensitivity
- ☐ Gums sore
- ☐ Cracked
- ☐ Prior Treatment

Office Use Only

Appointment

Date	**Time**

Initials ____________________