Dr. Tamara Biary
Board-Certified Endodontist

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(617) 332-6232
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Patient Name ____________________ Patient Phone Number ______________ Date ____________

Referring Doctor ____________________ Referring Doctor Phone Number ________________

Appointment Status: Date ____________ Time ____________ ☐ Or Patient Will Call to Schedule

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

Reason for Referral

☐ Consultation: ____________________

☐ Root Canal Therapy: # ______________

☐ Endodontic Retreatment: # ____________

☐ Endodontic Surgery: # ______________

Restoration Considerations

☐ Post Space Requested? Y / N

☐ Sponge and Cavit Temp? Y / N

☐ Complete Core Buildup? Y / N

Diagnostic Information

☐ Percussion? Y / N Thermal? Y / N

☐ Sinus Tract: # ____________________

☐ Endodontic Care to Facilitate Restorative Care?

Please send recent radiographs.
PAs & BWs, if possible.

Exposure Date: ____________________

If Antibiotic started - Date & Regimen: ____

Comments: ____

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Please have your General Dentist complete this form and email it to our office at frontdesk@newtoncornerdentalcare.com.
If you do not have a general dentist, please call our office.

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