SCHOOL OF DENTISTRY
Oregon Health & Science University

**Department of Endodontology**
2730 SW Moody Ave ● Portland, OR 97201
Ph: 503-494-4248 ● Fax: 503-494-8486 ● Email: gradendo@ohsu.edu

Chart #:_____
*for office use only*

# ENDODONTIC REFERRAL FORM

Please EMAIL to **gradendo@ohsu.edu** or FAX to **503-494-8486** or MAIL to **SD ENDO 2730 SW Moody Ave, Portland OR 97201**. Thank you.

Date:_____

Scheduling Notes

## PATIENT INFORMATION

Last Name First MI

Home Telephone Other Telephone

Birth date **(13 years and older)** Male/Female Social Security #

*If under 18 years of age – Parent/Guardian*

Address

City State Zip

## REQUESTED TREATMENT:

- ❑ PA mailed
- ❑ PA emailed to gradendo@ohsu.edu
- ❑ Interpreter needed, **LANGUAGE**_____
- ❑ Private insurance: **NAME**_____
  **ID#/GROUP #**_____
- ❑ Patient covered on OHP or Washington Medical: **ID #:**_____

Referring Dentist

Address

City State Zip

Telephone Number Fax Number