

Mr.
Oliver Pontius, Dr., M.S.D.
Höhestraße 15

61348 Bad Homburg

Referring Doctor

Stamp

Date: _____

Phone: _____

REFERRAL

Fax: _____

- Endodontic diagnosis CBCT Diagnostic
- Microendodontic treatment Microscopic surgery

Phone cell: _____

Email: _____

PATIENT

Patient number: _____ Last name: _____ First name: _____

Date of birth: _____ Street, #: _____ City, zip code: _____

Phone home: _____ Phone cell: _____ Email: _____

ANAMNESIS

Medical history: _____

Tooth: _____

Dental history: _____

- Pulpitis Sinus tract Necrosis
- Acute apical periodontitis Chronic apical periodontitis Endodontically treated Acute periapical abscess

Other: _____

Build-up requested: _____

Post space requested: _____

Annex: _____

- Composite Quarz fibre post Yes Periapical x-ray and periodontal
- Cast post and core Zirconia/Empress No probings of the tooth affected

Thank you for the submission of the required documents and also for the confidence you are placing in us. We assure you that we will do everything possible to treat your patients to achieve the best outcome for them.

In accordance with the General Data Protection Regulation (GDPR), we ask you for the additional indication of the patient number, which assigned to the patient in your practice. Under this number, the exchange of information can continue to take place anonymously e.g. through e-mail.

Thank you very much!

Your specialist practice for endodontics