George Billis
BDS, MSc (Endodontics)
Practice Limited to Endodontics

Please send the Referral Form to:
Billis Endodontics
Gateway Dental
73 Station Road, Burgess Hill
West Sussex RH15 9DY

ENDODONTICS

www.billis-endodontics.co.uk
info@billis-endodontics.co.uk
M : 07826396852

Endodontic Referral Form

REFERRING DENTIST

Name:.....

Practice:.....

Address:.....

..... Post Code: ……..

Tel: ..... Email: .....

PATIENT DETAILS

Name: .....DoB:.....

Address: .....

..... Post Code: .....

Tel: (H).....(W).....(M).....

E- mail: .....

PATIENT MEDICAL HISTORY

.....

.....

.....

REFERRAL DETAILS

Which tooth/teeth require endodontic assessment/treatment? .....

Please describe the history of the patient's complaint, symptoms and clinical signs:.....

.....

.....

.....

Have you enclosed any radiographs? Y ☐ N ☐ (please tick as appropriate)

Signed: .....Date: .....