

George Billis

BDS, MSc, Specialist in Endodontics
Practice Limited to Endodontics



ENDODONTICS

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

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

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.....
.....

REFERRAL DETAILS

Which tooth/teeth require endodontic assessment/treatment?

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

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.....
.....

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

Signed: Date: