



Dr. Benjamin Farham, DMD

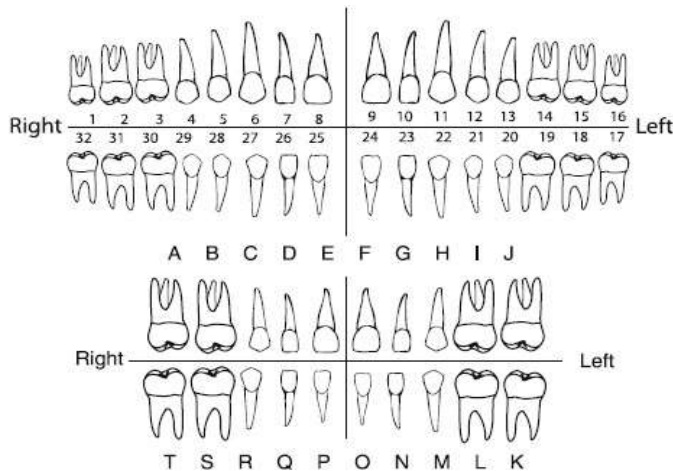
Date: _____

Patient Name: _____ Patient Date of Birth: _____

Patient Phone Number: _____

Referred by: _____ Phone Number: _____ Email: _____

Please Circle:



Reason for Referral:

- Pain Diagnosis and Treatment
- Endodontic Retreat
- Possible Root Fracture
- Resorption
- Other: _____

Restorative Considerations:

- Place Permanent Restoration
- Place Temporary Restoration
- Leave Post Space

Comments: _____