Endodontic Referral

Dr. Ryan Margel, DDS, MSc., FRCD (C)

Clarence Street DENTAL Group

Patient's Name: _____

DOB: _____

Phone #: _____

Email Address: _____

Referring Doctor: _____

Clinic Phone #: _____

Clinic Email: _____

Tooth/Teeth to be treated:

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Other tooth to be treated (ie. Primary/supernumerary): _____

History of Tooth: _____

Type of treatment:

❑ Root Canal ❑ Retreatment ❑ Apicoectomy

- Sedation Needed? ❑ Yes ❑ No

X-rays to be emailed at time of referral: _____

***At Clarence Street Dental, we require payment at the time of service.**
We will submit to your insurance carrier on your behalf for your reimbursement.
Your appointment can be paid by Visa, Mastercard or Debit.
We regret to inform you that we do not accept ODSP or HSO as a form of payment.

519-756-8080 lcarver@clarencestreetdental.com
1325 Clarence St S, Unit 1, Brantford, ON N3S 0C7