Endodontic Associates of Central Texas

Practice limited to Endodontics – Dr. Brian Bickel DDS and Dr. Michael W Ford DDS, MS

Download this form at: www.EACenTex.com

410 E Central Texas Expwy, Harker Heights

Fax: **(254) 519 - 3638** || **Office Phone**: **(254) 554 – 3636**

Patient Referral: Doctor's name: _____ Office: _____

Date: _____ Patient Name: _____

DOB: _____ Phone: _____ Email: _____

Tooth Number: _____ (Circle all that apply below)

Is the patient in Discomfort NOW? YES / NO

Is this an Emergency? YES / NO

Xray? YES / NO Date Taken: _____

Please email Xrays to**: office@eacentex.com**

Does the tooth have a Crown? YES / NO Tx Plan to Replace Crown? YES / NO

Preferred Restoration: Cavit / Orifice Seal / Core Build Up / Crown Repair

Would you like us to place a Post? YES / NO / Post Space

Insurance Information:

Insurance Name: _____ Number: _____

Subscriber's Name: _____ DOB: _____

Subscriber's SSN: _____ ****See Insurance Note Below****

****Please note**: Endodontic Associates accepts any insurance payments that will allow benefits to be assigned/paid to our office. For any insurance companies that will not pay our office: As a courtesy we will file the claim and the insurance company will send reimbursement directly to the patient. ******

Doctor's Care Notes:

_____

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