



# Dr. Tamara Biary Board-Certified Endodontist

1174 S Washington St., Suite 400

North Attleboro, MA 02760

(774) 331-0260

frontdesk@attleborodentalgroup.com

Patient Name \_\_\_\_\_ Patient Phone Number \_\_\_\_\_ Date \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Referring Doctor Phone Number \_\_\_\_\_

Appointment Status: Date \_\_\_\_\_ Time \_\_\_\_\_  Or Patient Will Call to Schedule

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

### Reason for Referral

- Consultation: \_\_\_\_\_
- Root Canal Therapy: # \_\_\_\_\_
- Endodontic Retreatment: # \_\_\_\_\_
- Endodontic Surgery: # \_\_\_\_\_

### Diagnostic Information

- Percussion? Y/N Thermal? Y/N
- Sinus Tract: # \_\_\_\_\_
- Endodontic Care to Facilitate Restorative Care?

If Antibiotic started - Date & Regimen: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Restoration Considerations

- Post Space Requested? Y/N
- Sponge and Cavit Temp? Y/N
- Complete Core Buildup? Y/N

**Please send recent radiographs.  
PAs & BWs, if possible.**

Exposure Date: \_\_\_\_\_

**Please have your General Dentist complete this form and email it to our office at frontdesk@attleborodentalgroup.com. If you do not have a general dentist, please call our office.**

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