Endodontic Request Form

PRIORY DENTAL CARE

Patient Details

Title: First Name: Surname:

Address:

Postcode:

Date of Birth: Email:

Telephone: Mobile:

Referring Dentist Details

Dentist name: GDC No:

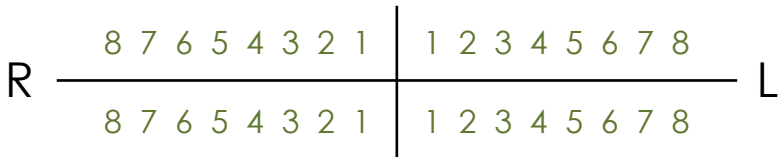
Practice Address:

Postcode: Telephone:

Email:

Reason for referral:

Please indicate tooth / teeth for Endodontic treatment



Endodontic Consultation Fee £50 (*as at 01/01/2026)*

Treatment fees from £660, depending on tooth type and complexity. A full written treatment plan will be provided following consultation.

Radiograph(s) attached: ☐ Periapical ☐ OPG ☐ No Radiographs
Filling required: ☐ Temporary ☐ Permanent

☐ I confirm that treatment options and estimated costs have been discussed with the patient, and patient has shown an active interest in endodontic therapy.
☐ I confirm that the patient can tolerate the use of rubber dam and periapical radiography

Referring Dentist Signature: Date:

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