



**ENDODONTIC  
SPECIALISTS**

Vahid Atabakhsh, D.D.S.

24401 104th Avenue SE

Kent, WA 98030

Phone: (253) 850-6999

Fax: (253) 852-1332

Referring Doctor:

Introducing:

Patient Information:

Address:

Home Phone: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Tooth No. \_\_\_\_\_ Radiograph Available? Yes \_\_\_\_\_ No \_\_\_\_\_

Referred for:

Evaluation Only \_\_\_\_\_ RCTX \_\_\_\_\_ Emergency \_\_\_\_\_

**Treatment Initiated:**

- Restoration - no exposure
- Excavation w/ exposure
- Pulp Cap
- Pulpotomy
- Partial Extirpation
- RCT Started
- None

**Restoration Preferred:**

- Post Space
- Post Buildup
- Restore Access
- Temporary Filling

**Medications: (Please specify)**

Antibiotics \_\_\_\_\_

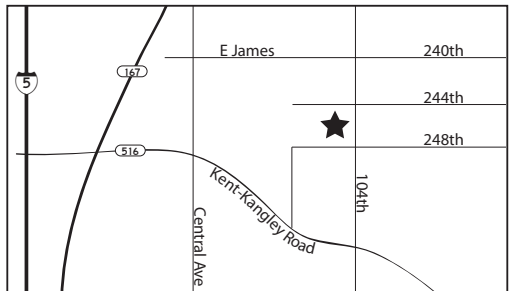
Pain Med \_\_\_\_\_

Require Pre-Medication Yes \_\_\_\_\_ No \_\_\_\_\_

Specify Condition \_\_\_\_\_

**Additional Comments:**

\_\_\_\_\_  
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SPECIALIST MEMBER