ENDODONTIC SPECIALISTS

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Referring Doctor:

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Introducing:

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Patient Information:

Address:

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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

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