



ENDODONTIC AND IMPLANTOLOGY ASSOCIATES

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PLEASE DO NOT TAKE ANY PAIN MEDICATION AT LEAST SIX HOURS PRIOR TO YOUR INITIAL APPOINTMENT.

DATE _____

INTRODUCING _____ TOOTH # _____

REFERRED BY _____

- PLEASE TAKE X-RAY ORIGINAL X-RAY ATTACHED
 DIGITAL X-RAY HAS BEEN FORWARDED TO XRAY@ENDOSJ.COM

Additional digital X-rays may be taken for diagnostic purposes.

SERVICES ALREADY PERFORMED:

- TOOTH HAS BEEN OPENED, MEDICATED AND SEALED
 PATIENT HAS BEEN PLACED ON AN ANTIBIOTIC AND / OR ANALGESIC

ENDODONTIC SERVICES REQUESTED:

- EVALUATE AND TREAT AS INDICATED
 EVALUATE FOR SURGERY OR RETREATMENT
 LEAVE POST SPACE
 DO POST AND CORE BUILDUP

OTHER / COMMENTS _____

CANDIDATE FOR SEDATION (Patient will require initial consult prior to treatment)

IMPLANT SERVICES REQUESTED:

- EVALUATE FOR IMPLANT
 EVALUATE FOR EXTRACTION/GRAFT
 EVALUATE FOR RIDGE AUGMENTATION
 EVALUATE FOR SINUS LIFT

IT IS MY INTENTION TO RESTORE THE INVOLVED TOOTH WITH:

DOWEL POST CROWN COMPOSITE OTHER _____

APPOINTMENT:

Date

Time

Doctor