ENDODONTIC &
IMPLANTOLOGY
ASSOCIATES

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

INTRODUCING_____ **DATE:**_____

TOOTH # _____

REFERRED BY_____

□ Please take X-ray □ Original X-ray attached

* Please note additional 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:

□ Consultation only
□ Evaluate and treat as indicated
□ Evaluate for surgery or retreatment
□ Leave post space
□ Do post and core build up
□ This tooth has had previous root canal treatment
□ Candidate for sedation (patient will require initial consult prior to treatment)
□ Other/ Comments:_____

IMPLANT SERVICES REQUESTED:

□ Evaluate for implant
□ Evaluate for extraction/ graft
□ Evaluate for sinus lift
□ Evaluate for ridge augmentation

IT IS MY INTENTION TO RESTORE THE INVOLVED TOOTH WITH:

□ Dowel post □ Crown □ Composite □ Other: _____

APPOINTMENT:

Date: _____ Time:_____ Doctor:_____