ENDODONTIC & 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

* 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:_____