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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: _____