Advanced Clinical Endodontics

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DATE: ____________________

I am referring: ________________________________ DOB: ________ Phone: ________________

______	Consultation / Diagnosis	______	Composite Core	______	IV Sedation
______	Root Canal	______	Post and Composite Core	______	Pre-Medicate
______	Re-Treatment	______	Post Space	______	Medical Alert
______	Apicoectomy	______	Temporary Filling	______	Please Call Us

May we reduce the occlusion? Yes ______ No______

Medication Given: ____

Comments: ____

Right 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Left
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Dr. ____________________________ Phone: ____________ Email: ____________________

We strongly recommend you arrange an immediate appointment with your referring dentist following the completion of the treatment at our office.

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