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R a n c h o E n d o d o n t i c s

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Introducing _____

Last

First

Middle

Today's Date: _____

Referring Doctor: _____

*** NO PAIN MEDICATION SIX HOURS BEFORE CONSULTATION.**

TOOTH #

Right

Left

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

Radiographs: Mailed Given to Patient Please take E-Mail

Remarks: _____

PLEASE SEND MORE REFERRAL SLIPS.

- Please evaluate.**
- Patient is having pain; please treat as needed.**
- Endodontics necessary for restoration.**
- Vital pulp exposure; please treat as needed.**
- Tooth has been opened and the following treatment completed:** _____
- Prior endodontic treatment.**
Evaluate for retreatment or surgery.
- Post space only** **Cement endodontic post.**
- Place final restoration:** _____
- Build up for full coverage.**

Appointment Date:

Day <input type="text"/>	Date <input type="text"/>	Time <input type="text"/>
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white: Patient's Copy yellow: Referring Doctor's Copy

