LAKESIDE ENDODONTICS

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One Appointment Microscope Endodontics

Patient's Name _____ Today's Date _____

Appt. Date _____ Time _____

Referred by _____ Phone _____

TOOTH/AREA IN QUESTION _____

HISTORY

- ☐ Pain ☐ Cold ☐ Hot
- ☐ Swelling
- ☐ Bite Sensitivity
- ☐ Pulp Exposure
- ☐ Periapical Radiolucency
- ☐ Fracture / Crack
- ☐ Trauma
- ☐ RCT Initiated

DESIRED TREATMENT

- ☐ Consult Only
- ☐ Conventional RCT
- ☐ Retreatment
- ☐ Surgical RCT
- ☐ Other (please explain below)
- ☐ Provide Post Space

Comments: _____

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Specialists in Endodontics and Microsurgery

COMMITTED TO EXCELLENCE