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Patient Name _____ Date _____
Patient Phone # _____
Referred by (Dr. & Office names) _____

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
- ☐ Provide Post Space
- ☐ Other (please explain below)
- ☐ CBCT

Comments: _____

Specialists in Endodontics and Microsurgery

COMMITTED TO EXCELLENCE



AUTHORIZED PROVIDER

