## REFERRAL FOR ENDODONTIC EVALUATION

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NNOVATIVE COMPREHENSIVE EXCELLENT

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Name							Date										(	Comm	nents/	Requ	estec	Corc	onal F	Resto	ratior	լ:
Daytime Phone Number																										
Referred By																										
Appointment Date																										
Molars			Bicu	spids		Anterior					Bicu	ıspids	Molars				_									
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											
Treatment Requested History																										
☐ Examine and treat as necessary								☐ Acute symptoms (pain, sensitivity, swelling)																		
☐ Examination/diagnosis only							☐ Periapical radiolucency																			
☐ Endodontic microsurgery/apicoectomy								☐ Pulp exposure																		
☐ Prepare post space								☐ Tooth has been previously opened																		
☐ Surgical crown lengthening								☐ Previous endodontic treatment																		
☐ CBCT Scan								☐ 0ther																		
□ Pe	ermane	ent filling												-												

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Patients can log onto our secure website and conveniently complete Patient Registration, Medical History and Pain History online prior to the appointment. Please contact our office for an ID and Password.