ALLEN COUNTY ENDODONTICS

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Practice Limited to Endodontics

Patient Name: _____ Phone: _____

Referring Doctor: _____ Date: _____

Please circle teeth for endodontic consideration

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

Referred For The Following:

- ❑ Diagnosis Only
- ❑ CBCT Scan
- ❑ Root Canal Treatment
- ❑ Retreatment
- ❑ Apicoectomy
- ❑ Restorative Purposes
- ❑ Nitrous Oxide
- ❑ Oral Sedation

Preference:

- ❑ Sponge +Temp Fill
- ❑ Intraorifice Barrier + Temp Fill
- ❑ Access Closure / Buildup
- ❑ Post Space Preparation
- ❑ Other (see remarks)

If Extraction Is Necessary:

- ❑ Refer back to my office
- ❑ Refer to:

Remarks

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