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Practice Limited to Endodontics

Patient Name: _____

Patient 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
- ☐ Nitrous Oxide
- ☐ Oral Sedation

Preference:

- ☐ Sponge +Temp Fill
- ☐ Intraorifice Barrier +
Sponge+Temp Fill
- ☐ Composite Resin
- ☐ Post Space Preparation
- ☐ Other (see remarks)

If Extraction Is Necessary:

- ☐ Refer back to my office
- ☐ Refer to:

Remarks
