skyway endodontics

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Patient: _____ DOB: _____ Date: _____

Contact #: _____ Referring Doctor: _____

Email Address: _____ RX Given: _____

Tooth or area to be treated: _____ Appt. Date: _____ Time: _____

Please email X-ray and referral to: info@skywayendo.com

Schedule Patient for:

☐ **EVALUATION ONLY**
- ☐ Prior RCT
- ☐ Trauma
- ☐ Questionable Prognosis
- ☐ Possible Fracture
- ☐ Scan Only - No Evaluation requested

- or -

☐ **EVALUATION & TREATMENT**
- ☐ RCT needed for Restoration
- ☐ Pulp Exposure
- ☐ Opened and Medicated
- ☐ Radiolucency
- ☐ Pain

Additional Information to Assist Your Patient: _____

_____

Insurance Information _____ Subscriber: _____ DOB: _____

ID# _____ Pending: _____ Employer: _____

Top copy to Skyway Endodontics : Bottom copy to Patient

SPECIAL INSTRUCTIONS:

- No Pain Medication 6 hours prior to appointment
- Appointments need to be confirmed the day prior
- Please have your patient registration completed prior to appointment

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