DOWNTOWN HAMILTON ENDODONTICS

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REFERRING DR: _____ PHONE: _____

DATE OF REFERRAL: _____

PATIENT NAME: _____ PHONE: _____

APPOINTMENT DATE: _____ TIME: _____

RIGHT	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	LEFT
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	

PLEASE COMPLETE ALL THAT APPLY

TENTATIVE DIAGNOSIS: _____

- ☐ PATIENT HAS DISCOMFORT / PAIN
- ☐ TRAUMATIC INJURY: _____
- ☐ ENDO TX INITIATED
- ☐ PULP EXPOSED
- ☐ RECENT DENTAL TREATMENT: _____
  _____
- ☐ PREVIOUS ROOT CANAL TREATMENT
  HOW LONG AGO? _____
- ☐ MEDICAL HISTORY: _____
  _____
- ☐ PROPHYLACTIC ENDO TREATMENT REQUIRED
- ☐ BRIDGE / CROWN (TEMPORARY / PERMANENT?)
- ☐ POST SPACE REQUIRED
  IN WHICH CANAL? _____
- ☐ X-RAY: ENCLOSED / EMAILED
- ☐ SEDATION REQUIRED: NITROUS / ORAL

COMMENTS: _____

_____

_____

COMPLEMENTARY PARKING
LOCATED IN LOT EAST OF BUILDING

Take ticket from parking attendant if present.
Otherwise, please use machine and select appropriate time.
Place original in your car and press 1 for a duplicate to bring to office reception for reimbursement.