RIVER STREET ENDODONTICS

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Today's Date: _____

Name: _____ DOB: _____

Phone: _____ Address: _____

Referred by: _____ Doctor's phone: _____

PLEASE MARK TEETH TO BE TREATED

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

RADIOGRAPH

☐ Mailed ☐ Emailed ☐ With Patient

TOOTH STATUS

☐ Recent Restoration ☐ Deep Caries or Pulpal Exposure

☐ Pulptomy or Pulpectomy Initiated ☐ Previous Endodontic Treatment/Surgery

☐ Traumatic Injury ☐ Suspected Fracture

TREATMENT DESIRED

☐ Consultation ☐ Root Canal Therapy ☐ Re-treatment ☐ Apical Surgery

☐ Other/or Special Instructions:

_____

_____

RESTORATIVE INSTRUCTIONS

☐ Temporary Restoration ☐ Post Space Requested ☐ Place Core Build Up

☐ Any Requeststs/Specifics:

_____

_____

ADDITIONAL COMMENTS

☐ Patient requires prophylactic medication ☐ Patient requires nitrous oxide

☐ Patient requires oral sedation ☐ Medical history or medications:

_____

_____