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Endodontics

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Patient's Name & Birthdate _____

Phone Number _____
(HOME) (WORK) (CELL)

Appointment _____

Please come 10 minutes early to complete registration forms.
Bring this referral slip and insurance information.

Tooth/Area in Question: _____

Insurance Co. Name and address/phone #: _____

_____

Group# _____ ID# _____

HISTORY:

- ❑ Pain
- ❑ Pulp Exposure
- ❑ Pulp Cap
- ❑ Trauma
- ❑ Apical Radiolucency
- ❑ Swelling
- ❑ Fracture
- ❑ Periodontal Condition
- ❑ Previous RCT

Date _____

TREATMENT CARRIED OUT SO FAR:

- ❑ Occlusion Adjusted
- ❑ Sedative Dressing Placed
- ❑ Pulp Extirpation
- ❑ Rx Antibiotic _____
- ❑ Rx Analgesic _____
- ❑ ALLERGIES _____
- ❑ PRE MED

TREATMENT TO BE CARRIED OUT IN THE ENDODONTIC OFFICE:

- ❑ Consultation/Diagnosis only
- ❑ Endodontic therapy
- ❑ Endodontic therapy **with** core build up
- ❑ Leave post space
- ❑ Please phone me following examination

REFERRING DOCTOR'S COMMENTS:

_____

_____

_____

Referring Doctor _____ Date _____

Please visit our website @ santarosaendo.com