BUCKEYE
ENDODONTICS

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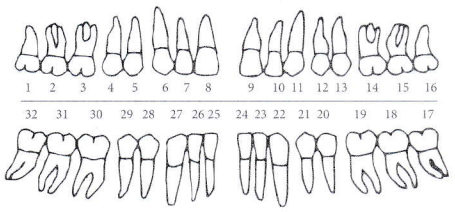
DATE:

DATE OF APPOINTMENT:

REFERRING DENTIST:

TIME OF APPOINTMENT:

OFFICE PHONE NUMBER:




INTRODUCING: _____

FOR ENDODONTIC CONSIDERATION ON:

**PLEASE CHECK ALL THAT APPLY:**

- ☐ Please evaluate and treat patient having:
  - ☐ Pain
  - ☐ Pain that is difficult to isolate
  - ☐ Swelling
  - ☐ Sensitivity to hot/cold
  - ☐ Biting discomfort
- ☐ Endodontics necessary for proper restoration
- ☐ Tooth has already been opened
- ☐ **Tooth has already had a root canal**
- ☐ Please prepare a post space
- ☐ Perforation/resorption repair
- ☐ Radiograph reveals pathology
  Rx:

Additional comments: