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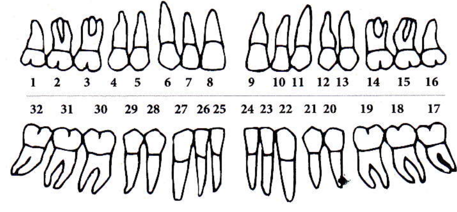
DATE: ______________________

PATIENT'S NAME: ______________________

PATIENT'S PHONE NUMBER: ______________________

REFERRING DENTIST: ______________________



REFERRING DENTIST PHONE & EMAIL: ______________________

PLEASE CHECK ALL THAT APPLY:

- ☐ EVALUATION ONLY
- ☐ Please treat the tooth/teeth as needed

PATIENT IS HAVING THE FOLLOWING:

- ☐ 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
- ☐ Patient has dental anxiety
- ☐ Perforation/resorption repair
- ☐ Radiograph reveals pathology

Rx prescribed for tooth:

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Additional comments:

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