



Endodontic Specialists

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DIPLOMATE, American Board of Endodontics
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ASHEVILLE PATIENTS

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HENDERSONVILLE PATIENTS

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Patient name: _____

Phone: _____ Fee: \$ _____

Referred by Dr. _____ Date: _____

Tooth # _____ Appt date: _____ Time: _____

Reason for Referral:

- Consultation only
- Endodontic treatment
- Retreatment
- Apical surgery

Pertinent History:

- Deep Periodontal Pocket
Location: _____
- Previous root canal
- Pain and/or swelling
- Periapical lesion
- Pulp exposure
- RCT required for restoration
- Traumatic injury

Radiographs:

- Sent by email
- Sent by mail

3D Imaging:

- Date Taken: _____
- Delivery Method: CD Digital transfer

Treatment Performed:

- Root canal initiated
- Recent restoration
- Antibiotics prescribed
Type: _____
- Pain medication prescribed
Type/Amount: _____
- Permanent Crown
- Temporary Crown

Restorative Instructions:

- Create post space

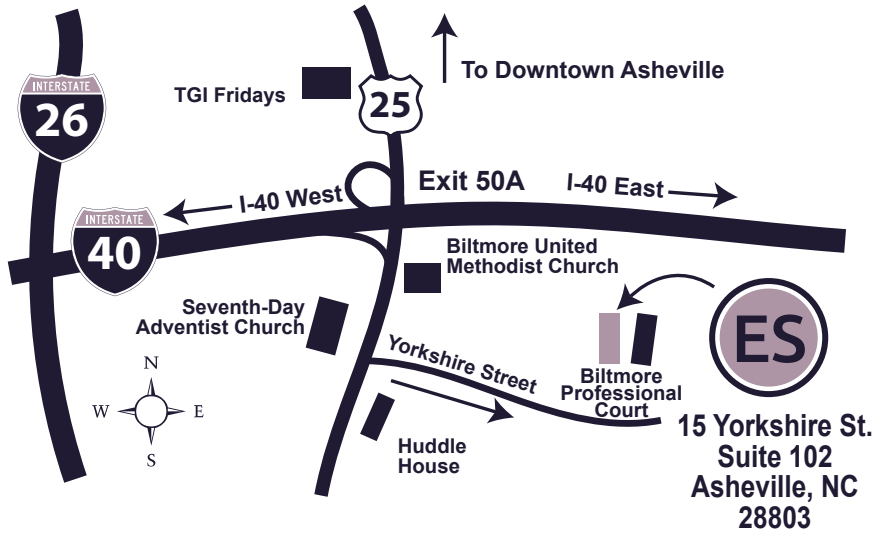
Oral sedation:

- Oral sedation
- I.V. sedation

Comments: _____

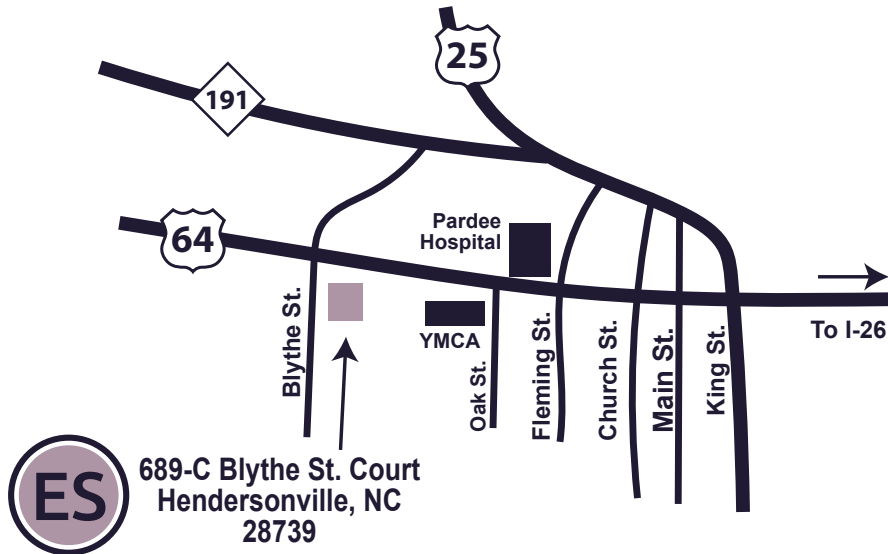
Please give 48 hours notice if you are unable to keep your appointment.

See reverse for maps and directions.



Asheville Office

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Hendersonville Office

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If you need any additional information, please contact either of our offices.

www.wncendo.com