



Endodontic Specialists

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HENDERSONVILLE PATIENTS

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Patient name: _____ Date of Birth: _____

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

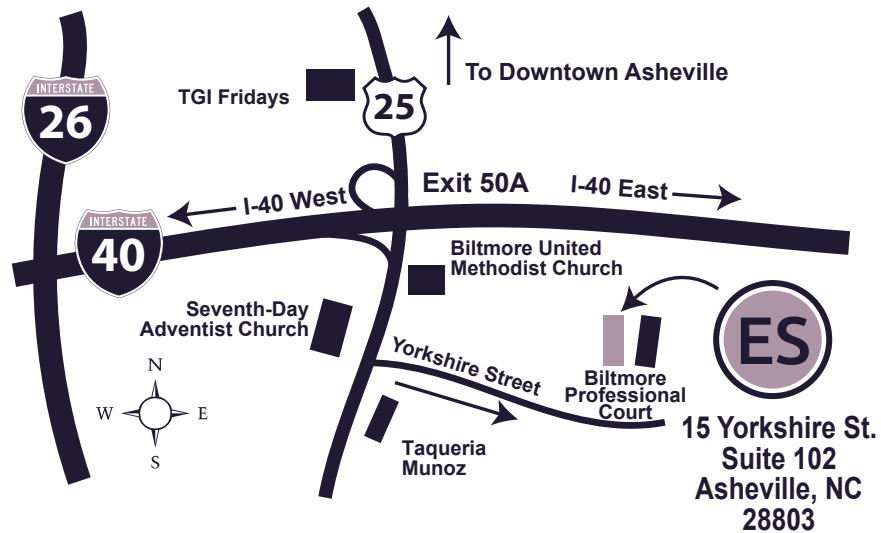
Oral sedation:

- ☐ 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.



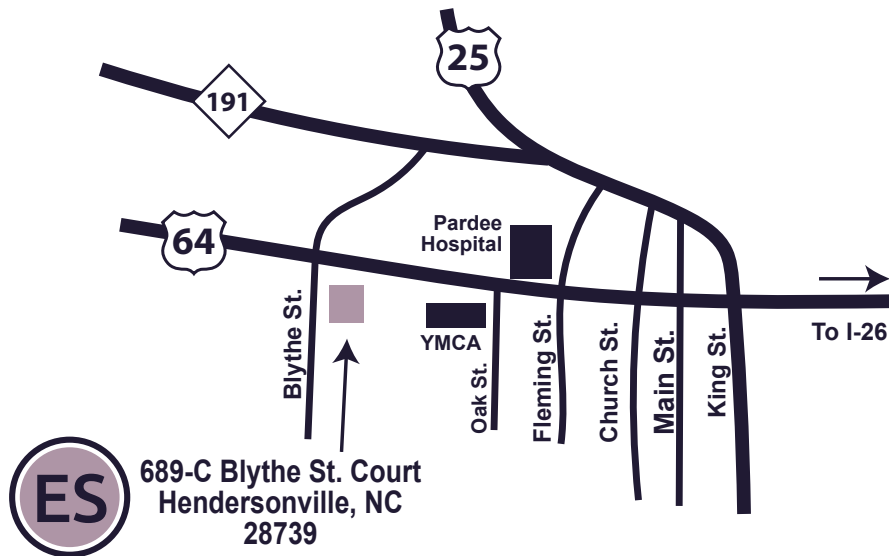
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If you need any additional information, please contact either of our offices.

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