DFW ENDODONTICS

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Patient Name _____ Patient Phone _____

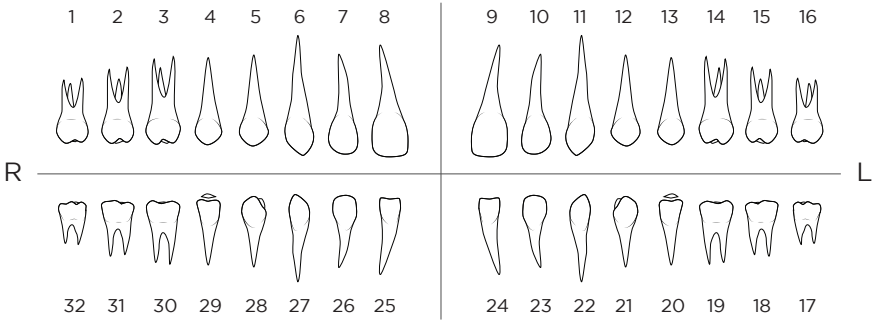
Referring Doctor _____ Date _____

Referring Office Phone# _____

Reason for Referral:

- ☐ Root Canal
- ☐ Retreatment
- ☐ Consultation
- ☐ Endodontic Surgery

Tooth Chart:



- ☐ Pain/Discomfort
- ☐ Asymptomatic
- ☐ Periapical Radiolucency
- ☐ Pulp Exposure
- ☐ Cracked Tooth
- ☐ RCT Initiated
- ☐ Previously Treated
- ☐ Trauma
- ☐ Please call me regarding patient

Tooth # or Area: _____

Comments: _____

_____

_____

After Treatment:

- ☐ Place Temporary Restoration
- ☐ Place Permanent Restoration
- ☐ Leave Post Space
- ☐ Other _____