Bart M. Rizzuto, D.D.S. Robert W. Berls, D.D.S.

www.capitaldistrictendodontics.com

Capital District Endodontics, PC

Patient's Name: _____ Patient's Phone #: _____

Referred by Dr.: _____ Dr.'s Phone #: _____

Appointment Date: _____ Time: _____

SERVICES NEEDED:

☐ Non-surgical RCT ☐ Re-treat/Apico ☐ Evaluation/Diagnosis

right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	left
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

STATUS:

☐ patient discomfort / emergency

☐ swelling

☐ radiographic / lesion / PARL

☐ tooth previously opened / pulpotomy or pulpectomy

☐ crack or fracture suspected

☐ crown or bridge is cemented

☐ temporarily ☐ permanently

POST SPACE REQUIRED:

☐ Yes ☐ No

REMARKS / COMMENTS:

_____

_____

_____

TO EXPEDITE SCHEDULING, PLEASE FAX THIS FORM TO (518) 382-2569 OR (518) 348-1159
AND MAIL OR EMAIL ANY X-RAYS BEFORE REMITTING TO PATIENT

Referring Dr.'s Signature _____ Date _____

CLIFTON PARK 947 Route 146 Clifton Park, NY 12065 Phone: (518) 348-1160 Fax: (518) 348-1159
NISKAYUNA 2317 Balltown Road, Suite 201 Niskayuna, NY 12309 Phone: (518) 377-1234 Fax: (518) 382-2569

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