

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:

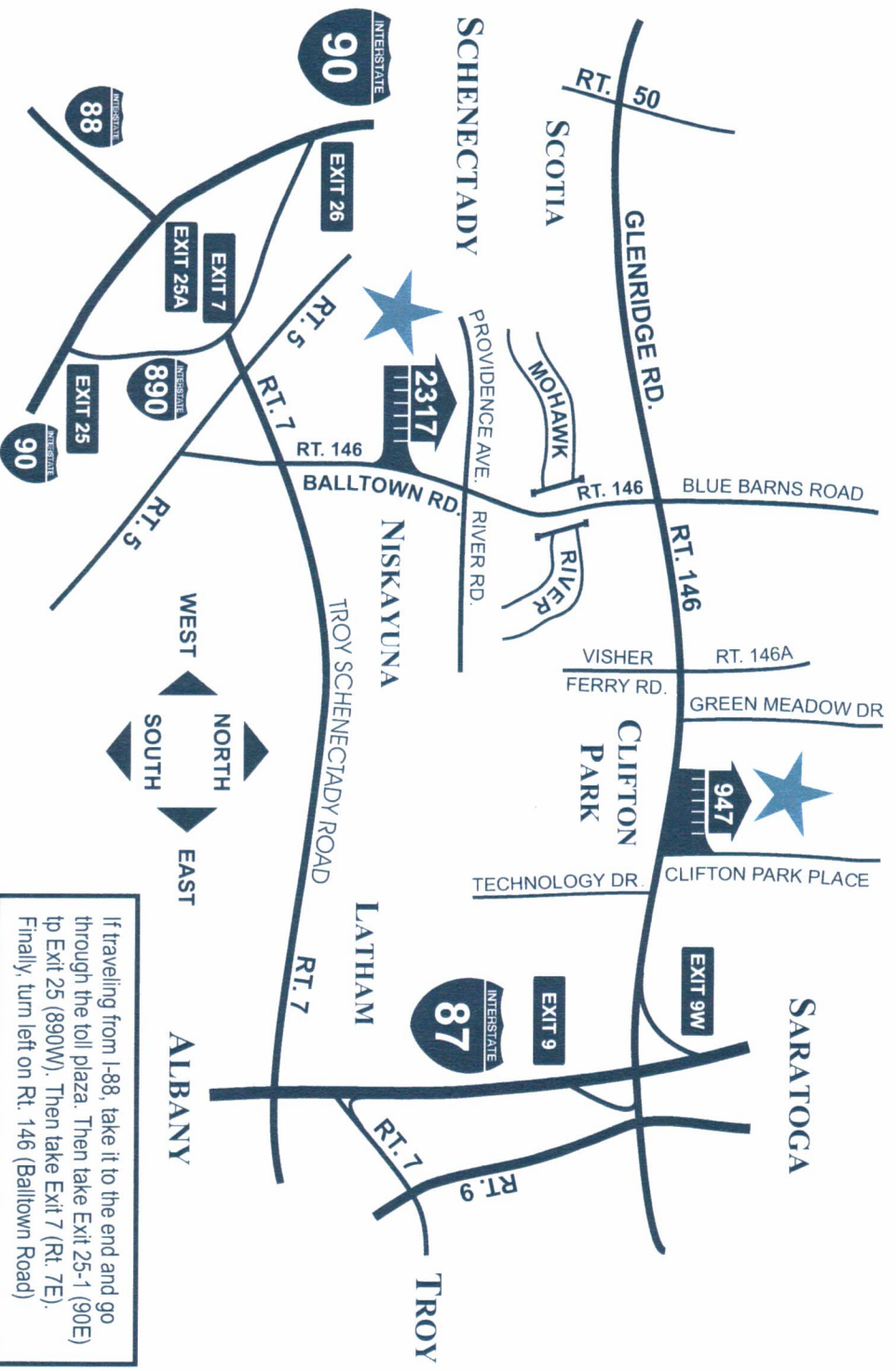
POST SPACE REQUIRED:

- patient discomfort / emergency Yes No
 swelling
 radiographic / lesion / PARL
 tooth previously opened / pulpotomy or pulpectomy
 crack or fracture suspected
 crown or bridge is cemented
 temporarily permanently

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 _____



If travelling from I-88, take it to the end and go through the toll plaza. Then take Exit 25-1 (90E) to Exit 25 (890W). Then take Exit 7 (Rt. 7E). Finally, turn left on Rt. 146 (Balltown Road)