

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

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

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:

Referring Dr.'s Signature: _____ Date: _____