Grand View
ENDODONTICS

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Practice limited to Endodontics

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Date _____

Introducing _____

Referred By Dr. _____

Phone # _____

Tooth in Question _____

Right **Left**

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

DENTAL HISTORY:

- ☐ Pain
- ☐ Pulp exposure
- ☐ Apical Radiolucency
- ☐ Trauma / Fracture
- ☐ New Crown to be made
- ☐ Periodontal condition
- ☐ Crown lengthening has been advised
- ☐ Other _____

SERVICES REQUESTED:

- ☐ Consultation Only
- ☐ Apical Surgery
- ☐ Root Canal Treatment
- ☐ Assist with Diagnosis
- ☐ Root Canal Retreatment
- ☐ Internal Bleaching
- ☐ Other _____
- ☐ Phone me following examination

AFTER TREATMENT:

- ☐ Post Space
- ☐ Core Build up
- ☐ Post & Core
- ☐ Temporary Cement Over Cotton
- ☐ Remarks _____

APPOINTMENT SCHEDULED FOR:

Day: _____ **Date:** _____ **Time:** _____