SAMARITAN ENDODONTICS

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PATIENT REFERRAL INFORMATION

First Name		**Last Name**		**Birth Date**	
Phone #		**Patient Email**			

TREATMENT INFORMATION

Tooth Number or Area _____

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Past Dental History

- ❑ Recent Restoration
- ❑ Antibiotics/Analgesics Prescribed
- ❑ Other/Comments

Services Requested

- ❑ Consultation Only
- ❑ CBCT Scan
- ❑ Evaluate and Treat as Indicated
- ❑ Evaluate for:
  - ❑ Restorability
  - ❑ Retreatment
  - ❑ Apicoectomy
  - ❑ Internal Bleach

After Completion of Root Canal Therapy

- ❑ Place Cotton and Temporary Restoration
- ❑ Provide Post Space
- ❑ Provide Build-up or Place Permanent Restoration in the Access Opening

Appointment Date _____ **Time** _____

This time is reserved exclusively for you. If you are unable to keep your appointment, 48 hours notice is required. Thank you.

REFERRING DOCTOR INFORMATION

Referred by Dr. _____ **Date** _____

Phone # _____

- ❑ **Please call before patient consultation**