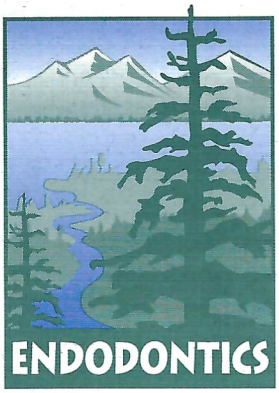

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PRACTICE LIMITED TO ENDODONTICS

American Association of Endodontists ® Specialist Members

INTRODUCING _____ DATE _____

HOME PHONE _____ CELL PHONE _____

REFERRED BY DR. _____ PHONE _____

APPOINTMENT DATE _____ TIME _____

PLEASE CIRCLE NUMBERS OF TEETH THAT MAY NEED TREATMENT

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

FOR THE FOLLOWING:

- ☐ EXAMINATION AND ROOT CANAL FILLING
- ☐ CONSULTATION AND DIAGNOSIS EVALUATE PAIN SYMPTOMS
- ☐ X-RAY REVEALED RADIOLUCENCY
- ☐ RETREATMENT OF PREVIOUS ENDO
- ☐ PULP WAS EXPOSED--VITAL
- ☐ PULP WAS EXPOSED--NON-VITAL
- ☐ APICOECTOMY--RETROFILL
- ☐ TREAT TOOTH WITH OPEN APEX
- ☐ PREPARE POST SPACE
- ☐ TRAUMA

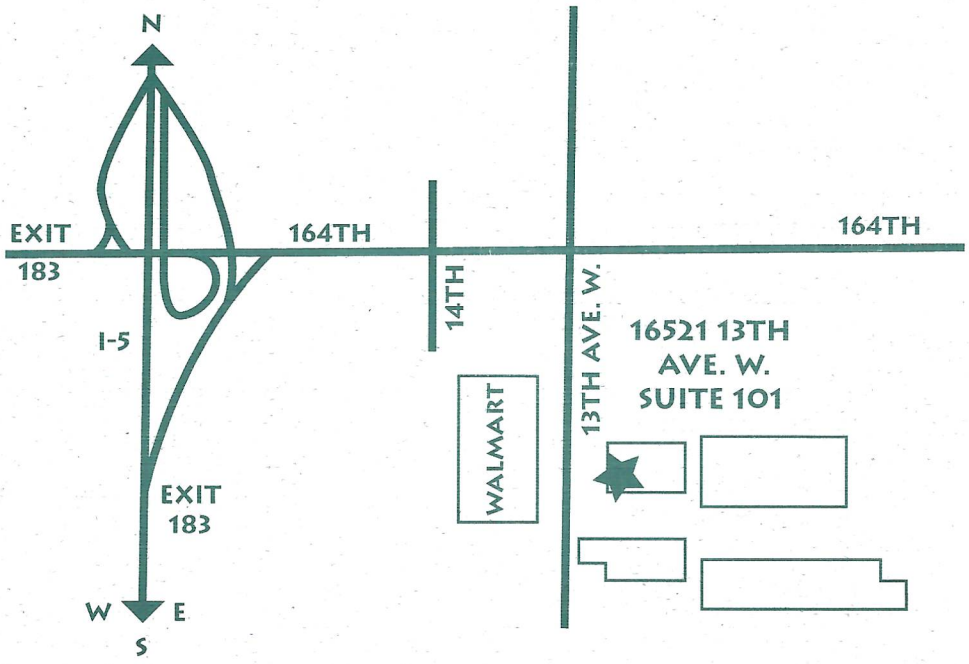
COMMENTS: _____

_____

_____

SUGGESTIONS FOR PATIENTS

1. PLEASE CALL FOR THE FIRST APPOINTMENT.
2. IF YOU ARE TAKING MEDICATIONS, PLEASE BRING THEM WITH YOU OR WRITE THE NAME AND DOSE OF THE MEDICATION, THE AMOUNT AND TIMES TAKEN.
3. MINORS MUST BE ACCOMPANIED BY A PARENT OR GUARDIAN.
4. PAYMENT IS DUE AT THE TIME OF SERVICE. IF TREATMENT IS COVERED BY INSURANCE, PLEASE BRING YOUR DENTAL INSURANCE CARD WITH YOU.



POS Reorder # 1517043