



CARE ENDODONTICS INC.
 Practice limited to *Endodontics*
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Date _____

PLEASE BRING THIS CARD TO YOUR APPOINTMENT

Patient Name _____

Appointment Date _____ AM
 _____ PM
 Month Day Time

TOOTH NUMBER OR AREA FOR CONSIDERATION

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

- Upper Right Lower Right Upper Left Lower Left

Is the tooth treatment planned for a crown restoration? Yes No

COMMENTS

SERVICE REQUESTED

- | | |
|---|---|
| <input type="checkbox"/> Consultation Only | <input type="checkbox"/> Assist With Diagnosis |
| <input type="checkbox"/> Treat As Needed | <input type="checkbox"/> Leave Post Space |
| <input type="checkbox"/> Root Canal Treatment | <input type="checkbox"/> Place Build-Up |
| <input type="checkbox"/> Root Canal Retreatment | <input type="checkbox"/> Place Post & Build-Up |
| <input type="checkbox"/> Endodontic Surgery | <input type="checkbox"/> Call Prior To Consult/Tx |
| <input type="checkbox"/> Intentional Endodontics For Restorative Reason | <input type="checkbox"/> CBCT Scan |
| | <input type="checkbox"/> Other: |

REFERRING DENTIST

OFFICE PHONE NUMBER

