Endodontic Care, P.C.

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Referring Doctor:____________________________Date of Referral:___/____/___

Introducing:____

Appointment Date:_______________Time:______________Office:____________

Please do not take any pain relievers 12 hours prior to your appointment.

Please do not have any caffeine the day of treatment.

Please bring this referral slip to your appointment.

Upper

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

Lower

Select one:

❒ Endodontic consult, Diagnosis uncertain
❒ RCT appointment, Diagnosis confirmed
❒ Dental implant consult

Present Status:

❒Pulp exposed
❒Severe pain or swelling
❒Suspect fracture
❒Bridge/Crown is cemented on:
❒Temporarily
❒Permanently

Requested Procedure:

❒Endodontic treatment, Non Surgical
❒Endodontic retreatment
❒Post removal / post space
❒Endodontic microsurgery
❒Dental implant(s)
❒Internal bleaching

Restoration intended: ❒Crown ❒Other ______________________________

Post space requested: ❒Yes ❒No ❒Determine at time of treatment

Have Endodontic Care place core: ❒Yes ❒No

Comments:____

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Please email referral slip and x-rays to **info@endodonticcare.com**

All patients are encouraged to complete their patient registration forms by visiting our website at **www.endodonticcare.com**

❁ Map on reverse ❁