



SUPERIOR ENDODONTICS

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Today's Date: _____

Appointment Date & Time: _____

Patient's Name: _____

Patient's Phone: _____

Referring Doctor: _____

Tooth/Teeth #: _____ Previous Endodontic Treatment? Y / N

REFERRED FOR THE FOLLOWING

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	

Evaluation and Consultation Only:

- Tooth Restorability
- Eval. for vertical root fracture

Evaluation and Endodontic Therapy as Indicated:

- Root Canal Therapy Retreatment Therapy
- Root-End Surgery / Apicoectomy

Restorative Requests:

- Temporize Access Prepare Post Space
- Permanently Restore Access

Remarks / Special Instructions / Symptoms / Medications given:
