❑ Kokomo ENDODONTICS

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1-800-932-6158
frontdesk@kokomoendo.com
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❑ HAMILTON COUNTY ENDODONTICS

14757 Oak Road, Suite 400 • Carmel, Indiana 46033
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Practice Limited to Endodontics

Referring Dr. _____ Patient Name: _____

Tooth Number: _____ Date Referred: _____

❑ **Appointment date & time:** _____ ❑ **Patient will call to schedule**

Status of the Tooth:

❑ Caries to the Pulp
❑ Hot/Cold Pain
❑ Biting Pain
❑ Swelling
❑ Apical Radiolucency
❑ Resorption
❑ History of Trauma
❑ Sinus Tract/Fistula
❑ Questionable Restorability
❑ Endo Necessary for Restoration
❑ Other: _____

Recent Treatment:

❑ Previous RCT
❑ Pulp Exposure
❑ New Filling/Crown
❑ RCT Started/Pulpotomy

❑ Rx Given: _____ ❑ Pre-Med Antibiotics: _____

Patient Requests: ❑ Oral Sedation ❑ Nitrous Oxide

The following procedures are not routinely performed unless requested:
❑ **Post space preparation** ❑ **Permanent restoration**

If it is determined a tooth needs to be extracted:
❑ Refer back to my office ❑ Refer to: _____

Comments: _____

_____

_____

_____

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