ROOT CANALS ROCK
ENDODONTICS

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DATE _____ REFERRING DENTIST _____

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT PHONE # _____ TOOTH # _____ APPT DATE/TIME _____

STATUS OF TOOTH

- ❍ Symptomatic
- ❍ Asymptomatic
- ❍ Trauma
- ❍ Possible Resorption
- ❍ Rx provided: _____

Recently restored with:

- ❍ Temp Crown/Bridge
- ❍ Permanent Crown/Bridge
- ❍ Other: _____

ENDODONTIC PROCEDURES REQUESTED

- ❍ Evaluate and treat as necessary
- ❍ Evaluate only/call before tx
- ❍ Please take CBCT
- ❍ Retreatment
- ❍ Surgical evaluation
- ❍ ELECTIVE (for restorative reasons)

RESTORE ACCESS WITH

❍ Core Buildup ❍ Temporary Filling ❍ Post Space

COMMENTS: _____

Please send a recent X-ray and any supporting information to **info@endorocks.com**
For more information please visit **endorocks.com**