PROFESSIONAL ENDODONTICS
OF ILLINOIS

Vladimir Tismensky, DDS
Mary Roman, DDS, MS
Yun Park, DDS, MS
Philip W. Cannizzaro, DMD, MS
Alayna Corden, DMD, MS

www.ProfEndoIllinois.com e-mail: ProfEndoIllinois@gmail.com

Chicago Ridge
10258 Southwest Hwy
Suite C
Chicago Ridge, IL 60415
ph: 708-576-8442

Mount Prospect
1660 Feehanville Dr.
Suite 225
Mount Prospect. IL 60056
ph: 847-965-9333

Joliet
903 N. 129th Infantry Dr.
Suite 200
Joliet, IL 60435
ph: 815-714-2324

Date: _____

Introducing: _____

Appointment Date: _____ **Time:** _____

Referring Doctor: _____ **Phone:** _____

Instructions: _____

_____

To Be Filled In By Dentist:

- ☐ **Patient is having pain, swelling, sensitivity. Please Evaluate.**
- ☐ **Endodontic treatment is necessary for proper restoration of tooth.**
- ☐ **Nerve was exposed.**
- ☐ **X-Ray revealed radiolucency.**
- ☐ **Root Canal treatment was started.**
- ☐ **Post prep is indicated.**
- ☐ **Evaluation for possible apical surgery.**
- ☐ **Retreatment.**
- ☐ **CBCT**

	Molars			Right Bicuspids		Anteriors			Anteriors			Left Bicuspids		Molars		
Upper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Lower	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

(circle teeth for endodontic consideration)

Information for Patient:

- You will be returning to your family dentist for final restoration after treatment.
- When calling for your appointment, please have your dental insurance information available.
- Please bring your dental insurance information to your appointment.

IN NETWORK WITH ALL PPO PLANS