BOULDER ENDODONTICS

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Date _____

Introducing _____ Patient Phone _____

Referred by Dr. _____ Office Phone _____

Appointment Date _____ Time _____

Tooth #_____

Please circle tooth (or teeth) to be evaluated:

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

Reason for Referral:
___ Consultation and CBCT
___ Schedule for initial treatment
___ Failing previous Root Canal
___ Resorption
___ Possible Cracked Tooth

Please check all additional information that applies:
___ Antibiotics have been prescribed
___ Pain meds prescribed
___ History of trauma
___ Pulp exposure
___ Pulp cap
___ Root canal initiated

Restorative Requests:
___ Place temporary filling
___ Please place core buildup
___ Please place post and core buildup
___ Leave post space and temporize

Miscellaneous:
___ Please call prior to treatment
___ Crown/bridge is on with temporary cement

Please have patient bring this form and insurance information to their appointment.
Patients are encouraged to visit www.aae.org for information regarding endodontic treatment.

Remarks _____

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american association of endodontists
specialist member