BRASELTON
ENDODONTICS

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PATIENT INTRODUCTION & REFERRAL

Patient's Name: _____ Date of Birth: _____

Referred by Dr: _____ Referral Date: _____

Please call to discuss ☐ Send more referral pads ☐

TOOTH OR REGION TO BE EVALUATED

RIGHT																LEFT
	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 Only ☐ Root Canal Therapy ☐ Retreatment / Apicoectomy ☐
Internal Bleaching ☐ Crack/Fracture ☐ Resorption ☐ Dental Trauma ☐

IF PRESENT, WILL EXISTING CROWN BE REPLACED?

Yes ☐ No ☐ If necessary ☐ Has provisional ☐

RESTORATIVE REQUEST

Sponge & Temp (default) ☐ Core Buildup ☐ Access Patch ☐
Post Space Preparation ☐ Place Post & Core ☐ Remove Existing Crown ☐

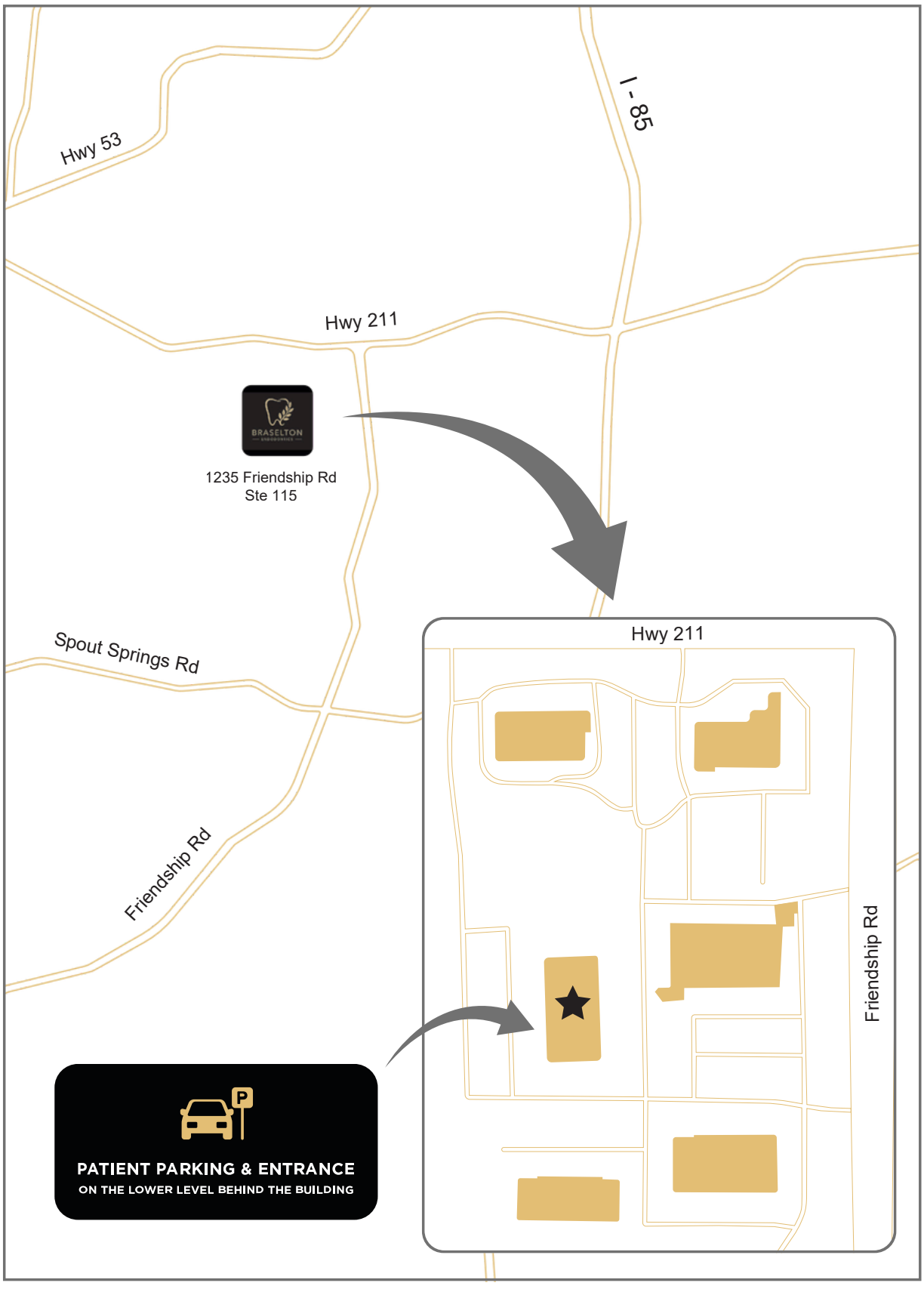
ADDITIONAL REMARKS

_____

_____

_____

HOW TO FIND US



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