SOCALDSC

*Practice Limited to **Endodontics***

Introducing: _____

has an appointment on

_____ / _____ / _____ AM PM

MONTH DAY TIME

TOOTH NUMBER OR AREA FOR CONSIDERATION

	UPPER RIGHT								UPPER 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
	LOWER RIGHT								LOWER LEFT						

If exists, is the crown restoration going to be replaced?

❑ YES ❑ NO ❑ IF NECESSARY

MEDICATIONS PRESCRIBED:

_____

SERVICE REQUESTED:

☐ CONSULTATION ONLY
☐ TREAT AS NECESSARY
☐ ROOT CANAL TREATMENT
☐ ROOT CANAL RETREATMENT
☐ SURGICAL ENDODONTICS
☐ INTENTIONAL ENDODONTICS FOR RESTORATIVE REASON
☐ ASSIST WITH DIAGNOSIS
☐ LEAVE POST SPACE
☐ PLACE BUILD UP
☐ PLACE POST & BUILD UP
☐ CALL ME PRIOR TO TREATMENT
☐ OTHER: _____

REFERRING DR.: _____

OFFICE PHONE NUMBER: _____

PLEASE BRING THIS REFERRAL WITH YOU, THANK YOU.