

APEX ENDODONTICS LLC
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Date: _____

Patient's Name: _____

Phone: Home _____ Work _____

Tooth (Teeth) to be evaluated: _____

Referring Dr.: _____

PRESENTING SYMPTOMS: (please check)

- None Thermal sensitivity Swelling
 Pain Bite sensitivity Drainage

SPECIAL INSTRUCTIONS:

- Nitrous Oxide Requested
 Intentional RCT Prior to Crown
 Provide Post Space
 Telephone Report Required After Consult After Treatment

COMMENTS: _____

APPOINTMENT:

Date: _____ Time: _____

★ MAP ON THE BACK ★