ST. PETERSBURG ENDODONTICS

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Please do not take pain relievers before your appointment so diagnostic test results can be accurate

Name _____ Appointment Time _____

Referred by _____ Teeth Involved _____

X-ray

(current x-ray with apices within 1 month of appointment, otherwise a new xray is needed)

- ☐ Sent with this referral
- ☐ Emailed to st.pete.endo@gmail.com
- ☐ New x-ray needs to be taken
- ☐ Regular mail

Referring dentist please select options

Current situation

- ☐ Patient has discomfort
- ☐ Periapical Pathosis
- ☐ X-ray indicates pulpal involvement
- ☐ Previous root canal
- ☐ Caries
- ☐ Possible resorption
- ☐ Fracture

Requested treatment

- ☐ Evaluation Only
- ☐ Evaluation and Treatment
- ☐ Root Canal Treatment
- ☐ Retreatment
- ☐ Post removal
- ☐ 3D cone beam imaging
- ☐ Endo needed to restore the tooth

Do you want the tooth prepared with a post space? ☐Yes ☐No

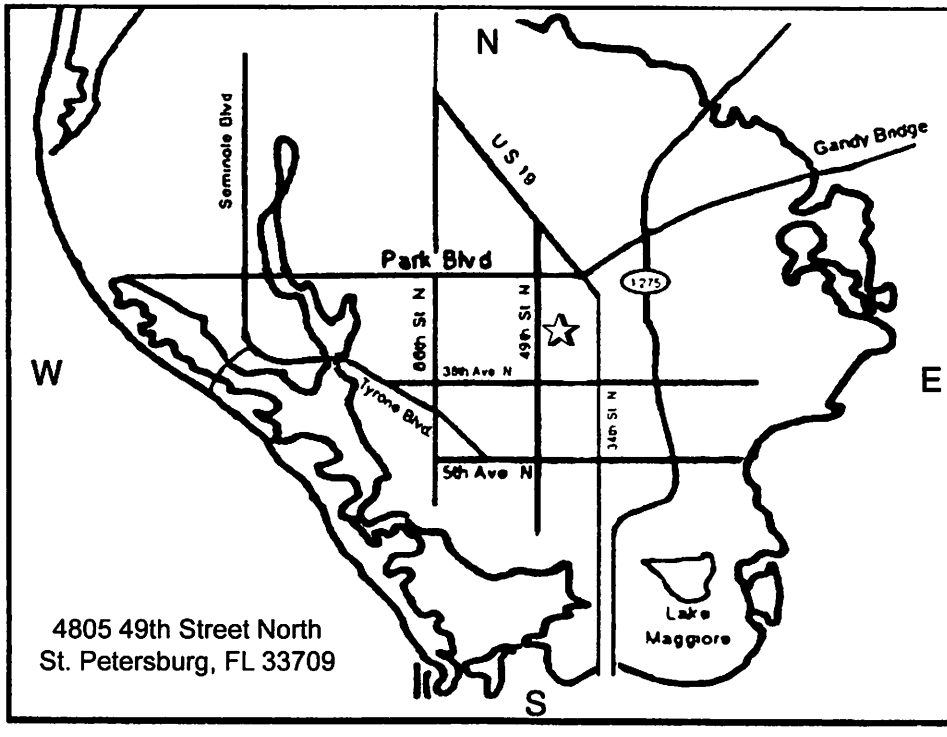
Please select your restorative preference

- ☐ Temporary filling
- ☐ Bonded amalgam filling
- ☐ Bonded composite filling
- ☐ Cement post and build up

Panoramic imaging ☐Yes ☐No

Dentist Notes / comments

SEE REVERSE SIDE FOR MAP AND DIRECTIONS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