AUBURN ENDODONTICS

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INTRODUCING ______________________ DATE __________

PATIENT PHONE (H.)__________________(W) __________

REFERRED BY DR.______________________________

PLEASE CIRCLE TEETH OR AREA FOR CONSIDERATION

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

ENDODONTICS CONCERNS:
PATIENT HAS SENSITIVITY TO:

☐ PRESSURE ☐ SWELLING ☐ HOT ☐ COLD ☐ PERCUSSION
☐ X-RAY REVEALED RADIOLUCENCY
☐ PREVIOUS ROOT CANAL

TREATMENT REQUESTED:
☐ CONSULT ONLY ☐ ENDODONTIC TREATMENT

COMMENTS/HISTORY OF CURRENT PROBLEM:
____
____

MEDICAL CONSIDERATIONS:
☐ MEDICATION ALLERGIES ☐ LATEX ALLERGY ☐ PRE-MED
____
____

RESTORATION: (PLEASE CHECK BOX THAT APPLIES)
☐ TEMPORARY ☐ COMPOSITE ☐ AMALGAM ☐ POST & CORE

POST SPACE: ☐ YES ☐ NO

APPOINTMENT DATE __________________ TIME __________

PLEASE ATTACH CURRENT X-RAY IF AVAILABLE
THANK YOU FOR HAVING CONFIDENCE IN OUR PRACTICE.