PREMIER ENDODONTICS TENNESSEE

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Patient Name: _____ *(Date)*_____

Referring Doctor: _____ *(Tel)*_____

Appointment Date and Time: _____

Reason for Referral: *(please check)*

- *Endodontic Consult and Diagnosis only*
- *Endodontic Consult and Treat as Necessary*
- *Endodontic Retreatment/surgery*
- *Treat for Restorative reasons (intentional endodontics)*
- *Cracked Tooth or pulpal exposure*

Tooth Number: *(please circle tooth):* Tooth# _____

Permanent Teeth															
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							

Patient exhibits: *(check all that apply)*

- *Toothache*
- *Pain and Swelling*
- *Fistula*
- *Bite tenderness*
- *Pain of unknown origin*

Restore access with:

- *Temporary:* **Cavit* **Glass Ionomer* **IRM*
- *Permanent restoration (Composite core)*
- *Post Space*
- *Post and core*

Notes: _____

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