PREMIER ENDODONTICS TENNESSEE

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Dr. David Long, DDS, MSD

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*

Please Circle Tooth Tooth No. _____

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
- ○ *Permanent Restoration (Composite Core)*
- ○ *Post Space*
- ○ *Post and Core*

Notes: _____