



ORANGE COUNTY ENDODONTICS

Ethan Do, DDS, MSD

Endodontic Specialist

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PLEASE BRING THIS FORM TO APPOINTMENT

Today's Date: _____

Patient Name: _____ Patient Phone: _____

Referring Office/Doctor: _____ Office Phone: _____

TREATMENT REQUEST

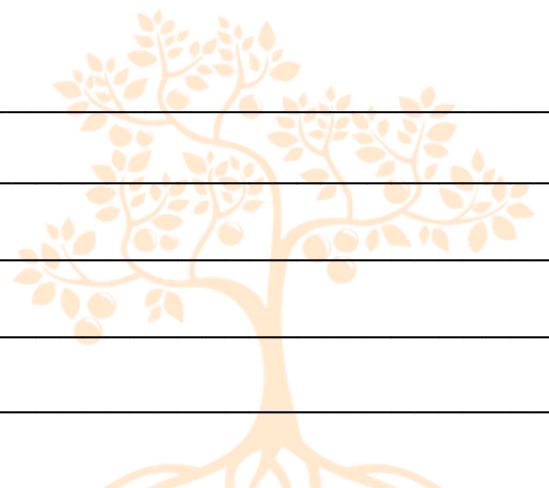
UPPER

	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	
R	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	L

LOWER

- | | | |
|---|--|---|
| <input type="checkbox"/> Consult Only | <input type="checkbox"/> Patient Has Pain | <input type="checkbox"/> Return Temporized |
| <input type="checkbox"/> Treat As Needed | <input type="checkbox"/> Patient Has Sensitivity | <input type="checkbox"/> Prepare Post Space |
| <input type="checkbox"/> Retreatment | <input type="checkbox"/> Tooth Has Been Accessed | <input type="checkbox"/> Post/Core Build-up |
| <input type="checkbox"/> Surgical Endodontics | <input type="checkbox"/> Canal Calcifications/Obstructions | <input type="checkbox"/> Core Build-up Only |
| <input type="checkbox"/> Ozone Therapy | <input type="checkbox"/> I Plan To Crown This Tooth | |

Additional Remarks: _____





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