ORANGE COUNTY ENDODONTICS

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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															L
32 ☐	31 ☐	30 ☐	29 ☐	28 ☐	27 ☐	26 ☐	25 ☐	24 ☐	23 ☐	22 ☐	21 ☐	20 ☐	19 ☐	18 ☐	17 ☐

LOWER

- ☐ Consult Only
- ☐ Treat As Needed
- ☐ Retreatment
- ☐ Surgical Endodontics
- ☐ Ozone Therapy
- ☐ Patient Has Pain
- ☐ Patient Has Sensitivity
- ☐ Tooth Has Been Accessed
- ☐ Canal Calcifications/Obstructions
- ☐ I Plan To Crown This Tooth
- ☐ Return Temporized
- ☐ Prepare Post Space
- ☐ Post/Core Build-up
- ☐ Core Build-up Only

Additional Remarks: _____

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EMAIL FORM

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