INNOVATION
COMMITMENT
COMFORT

GENTLECARE ENDODONTICS

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Diplomate American Board of Endodontics

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Date of Referral _____/_____/_____

Patient Name _____

Patient/Guardian Name if Minor _____

Patient Telephone _____

Referring Dentist _____

Name of Practice _____

Office Telephone _____

Office E-mail _____

Tooth Number or Area

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

History

- ○ Symptoms
- ○ Pulp exposure
- ○ Previous root canal treatment
- ○ Endodontic treatment initiated
- ○ Trauma
- ○ Periapical Radiolucency

Request

- ○ Evaluate
- ○ Evaluate and treat as needed
- ○ Post-operative request
- ○ Prepare post-space
- ○ Other _____

Other Comments

_____

_____

_____

Please bring this form and any other documents from your dentist to your appointment.