American Association of Endodontists
• Specialist Member

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Endodontist

Sedation Available

Date: _____ Telephone: _____

Name: _____

Address: _____

Appointment Date: _____ Time: _____

For endodontic evaluation and treatment of tooth number(s)
(please circle applicable numbers)

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

Patient presents with: *(please check appropriate areas)*

_____ • Pain
_____ • Pain to hot
_____ • Pain to cold
_____ • Pain during biting
_____ • Swelling
_____ • Fever

Special instructions *(Please check where applicable)*

_____ • Prepare post space
_____ • Sedation recommended
_____ • Radiographs included
_____ • Type of final restoration planned
_____ • Medications: _____

_____

Referred by: _____

Remarks: