



SOUND ENDODONTICS

Root Canal Specialists

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Introducing: _____ Phone: _____

Referred By: _____ Date: _____

Tooth# _____ Appointment Time: _____

FOR

- Examination and treatment as necessary
- Examination and consultation only

SYMPTOMS

- Temperature
- Spontaneous pain
- Biting pain
- Sinus tract
- Swelling
- None

TREATMENT / HISTORY

- Pulp was exposed
- Tooth was opened
- Prescription(s): _____
- Previous endodontic treatment
- Trauma / Fracture / Avulsion

RESTORATIVE

- Place a temporary filling
- Place a permanent filling
- Leave a post space
- Cement post and core

Comments:

_____ Take X-Ray _____ X-Ray Enclosed

Thank You For Your Referral

Referring Doctor (green copy) Patient Copy (ivory copy)