GOLDEN STATE
ENDODONTICS

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PATIENT: _____ DATE: _____

PATIENT EMAIL: _____ PATIENT PHONE: _____

REFERRING DOCTOR: _____

TOOTH # (AREA): _____

| | 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 | |

**TREATMENT DESIRED** (CHECK ALL THAT APPLY):
Please note consultation is preferred for previously treated teeth before scheduling treatment.

- ◯ CONSULTATION
- ◯ ROOT CANAL THERAPY
- ◯ SURGICAL ENDODONTICS
- ◯ ROOT CANAL RETREATMENT

**RESTORATIVE REQUESTS:**

- ◯ PLACE TEMPORARY RESTORATION
- ◯ PREPARE POST SPACE
- ◯ PLACE AMALGAM / COMPOSITE CORE RESTORATION
- ◯ PLACE POST & CORE

**PATIENT IS INTERESTED IN SEDATION:**

- ◯ NITROUS
- ◯ ORAL

**DENTAL INSURANCE INFORMATION:** _____

_____

_____

**COMMENTS:** _____

_____

_____

**APPOINTMENT INFORMATION:** DATE: _____ TIME: _____


Please assist us by providing the following information at the time of your consultation:

- Your treatment referral slip and any x-rays if applicable.
- A list of medications you are currently taking.
- If you have dental insurance, please provide us the following insurance information: Name of the insurance company, policy holder's name and employer, insurance I.D. number or social security number, date of birth of policy holder and the date of birth of the patient.

IMPORTANT:

All patients under the age of 16 must be accompanied by a parent or guardian at all appointments.

X-RAYS:

If your dentist has taken x-rays of the area in question, please bring them with you to your appointment.