GOLDEN STATE
ENDODONTICS

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PATIENT: ______________________ DATE: ______________

REFERRING DOCTOR: ______________________ PATIENT PHONE: ______________

TOOTH # (AREA) ______________________________________

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

TREATMENT DESIRED:

- ○ CONSULTATION
- ○ ROOT CANAL THERAPY
- ○ APICOECTOMY
- ○ ROOT CANAL RETREATMENT

RESTORATIVE REQUESTS:

- ○ TEMPORIZE ACCESS
- ○ PREPARE POST SPACE
- ○ PERMANENTLY RESTORE ACCESS
- ○ PLACE POST & CORE

COMMENTS: ______________________________________

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.