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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	L

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

- ○ Consultation Only
- ○ Consultation & Root Canal
- ○ Consultation & Retreatment
- ○ Consultation For Surgical Endodontics
- ○ Required RCT for Restorative
- ○ Pulp Exposure
- ○ Internal Bleaching

- ○ Existing Crown / Bridge
  - ○ Temporarily Cemented
  - ○ Permanently Cemented

RESTORATIVE REQUESTS:

- ○ Temporary Restoration
- ○ Post Space & Temporary Restoration
- ○ Permanent Restoration
- ○ Post & Buildup

PATIENT IS INTERESTED IN SEDATION:

○ NITROUS ○ ORAL

DENTAL INSURANCE INFORMATION: ______________________________

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COMMENTS: ______________________________

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APPOINTMENT INFORMATION: DATE: ______________ TIME: ______________

○ PLEASE SEND MORE REFERRAL PADS

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.