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GOLDEN STATE
ENDODONTICS

DATE: _____

PATIENT: _____ DOB: _____ EMAIL: _____

HOME PHONE: _____ CELL 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.

REFERRAL FOR:

- ◯ Consultation
- ◯ Consultation & Root Canal
- ◯ Consultation for Retreatment
- ◯ Consultation for Surgical Endodontics
- ◯ Existing Crown/Bridge
- ◯ Temporary Cemented
- ◯ Permanently Cemented

ADDITIONAL INFORMATION:

- ◯ Required RCT for Restorative
- ◯ Pulp Exposure

RESTORATIVE REQUESTS:

- ◯ Temporary Restoration
- ◯ Post Space & Temporary Restoration
- ◯ Permanent Restoration
- ◯ Permanent Restoration + Post

PATIENT IS INTERESTED IN SEDATION:

◯ NITROUS ◯ ORAL

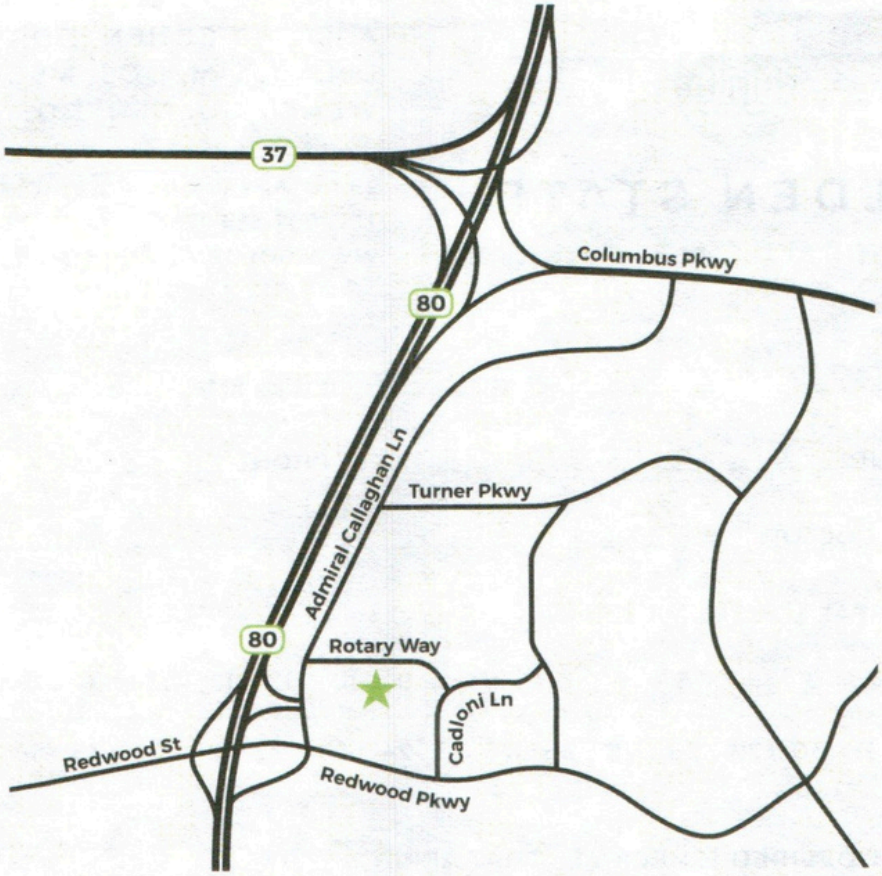
DENTAL INSURANCE: _____ **PRIMARY SUBSCRIBER:** _____

ID#: _____ **DOB:** _____

NOTES: _____

APPOINTMENT: 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:

We collect copays at the time of service: however, this amount is only an estimate. As a courtesy to you we will bill your insurance. Once your dental insurance processes the claim, our office will send a statement or issue a refund as needed.

All patients under the age of 18 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.