ENDODONTIC AND IMPLANT REFERRAL

SUMMIT ENDODONTICS

DR. TIM ADAMS, DMD

BOARD CERTIFIED ENDODONTIST
IV SEDATION AVAILABLE

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Date: _____

Patient Name: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Appointment Date and Time: _____

Reason for Referral:

- ○ Endodontic consult and treat as necessary
- ○ Implant
- ○ Endodontic retreatment/surgery
- ○ Treat for restorative reasons (intentional endodontics)
- ○ IV sedation (driver needed, NPO 8hrs before)

Tooth Number (please circle tooth):

PERMANENT TEETH

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

Patient Exhibits (check all that apply):

- ○ Toothache
- ○ Pain and swelling
- ○ Sinus tract
- ○ Bite tenderness
- ○ Pain of unknown origin

Restore Access With:

- ○ Temporary
- ○ Permanent restoration (composite core)
- ○ Post space
- ○ Post and core

Notes: _____

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Please give 48 hours notice if you cannot make your appointment