Coastal Endodontics

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Introducing_____ Date_____

Referred by Dr._____ Phone_____

Appointment: Day_____ Date_____ Time _____

Minors must be accompanied by parent or guardian.

Please circle the tooth/teeth to be examined:

	Molars	Premolars	Anteriors	Premolars	Molars	
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	

Referred for Consult

- □ Vague toothache symptoms
- □ Suspicious apical radiolucency
- □ Pulp status prior to crown
- □ Apical surgery
- □ Retreatment

Referred for Root Canal Therapy

- □ Pulp exposure
- □ Symptoms indicate need
- □ X-ray reveals need
- □ RCT needed for restoration
- □ Post space required

Comments_____

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Patient will be instructed to return to referring dentist for final restoration.
Thank you for the referral!

Patient Information

Welcome to our office! Endodontic (root canal) therapy is an attempt to save a tooth that would otherwise require extraction. We are committed to providing the highest quality endodontic care.

Please note:

- Payment is due at the time of service. VISA, Master Card & Discover are accepted for your convenience. For qualified applicants, financing may be available through Care Credit at www.carecredit.com

- Our office does not accept assignment of benefits from insurance companies. As a courtesy we will submit a claim to your insurance company for your reimbursement. ***Please bring your insurance card to your appointment.***

- Patients with an artificial joint placed within the past 2 years or an artificial heart valve, previous infective endocarditis, CHD or cardiac implant may require antibiotic premedication before treatment. ***Please contact our office prior to your appointment.***

For additional information and detailed directions to our office, visit our website at: www.obxendo.net