OCOTILLO LAKES
ENDODONTICS
ROOT CANAL SPECIALISTS

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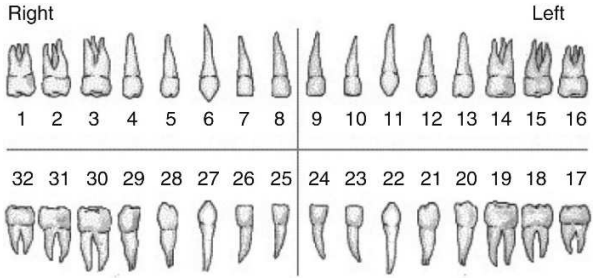
Date_____
Introducing_____ DOB_____Phone_____

Referred by Dr._____ Phone_____

PLEASE EMAIL CURRENT AND DATED PA & BW WITH REFERRAL
Please (Circle) teeth:



Please Schedule For:

- ☐ Evaluation
- ☐ CBCT
- ☐ Endodontics Necessary – Initiate Root Canal therapy
- ☐ Evaluate for Retreatment

Patient Requires Treatment Because:

- ☐ Patient has pain and / or sensitivity
- ☐ Patient has swelling
- ☐ Endodontics necessary for restoration
- ☐ Pulp was exposed (vital / nonvital)
- ☐ X-Ray Revealed Radiolucency
  - o Is a post space desired? No Yes
  - o Premedication required? No Yes
  - o Oral Sedation required? No Yes

Comments_____

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