UPPER EAST SIDE
ENDODONTISTS

Date: _____ Appointment: _____

Patient: _____ Patient DOB: _____

Referred by: _____

PLEASE CIRCLE TOOTH/TEETH:

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	

SERVICE ALREADY PREFORMED:

- ☐ Sedative Dressing Placed
- ☐ Pulpotomy/Pulpectomy
- ☐ Incision/Drainage
- ☐ Rx Antibiotic _____
- ☐ Rx Analgesic _____

SERVICE REQUESTED

- ☐ Consultation
- ☐ Cone Beam CT Scan
- ☐ Root Canal Treatment
- ☐ Root Canal Retreatment
- ☐ Endodontic Surgery
- ☐ Vital Pulp Therapy/ Pulp Cap (Pediatric)
- ☐ Apexogenesis
- ☐ Internal Bleaching

Coronal Treatment:

- ☐ Provide Post Space
- ☐ Provide Post/Core Buildup
- ☐ Place Temporary Restoration

Comments: _____

_____

_____

UPON TREATMENT COMPLETION

☐ Call Our Office ☐ Email Treatment Report ☐ Mail Treatment Report

Doctor's Signature: _____

☎ 212.988.6727 212.988.6726

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