BEAVERCREEK ENDODONTICS

Emily Lammers, DDS, MS
Saeed Zarrabi, DDS, MS

Patient's Name: _____

Date of Birth: _____ Phone: _____

Radiographs: ☐ Emailed to info@beavercreekohendo.com

☐ Please take radiographs ☐ Mailed

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

Reason for Referral:

- ☐ Consultation first to determine the best course of treatment
- ☐ Endodontic treatment needed, good restorative prognosis
- ☐ Evaluate for Retreatment or Apical Surgery
- ☐ Endodontics required for retention of coronal restoration
- ☐ Questionable restorability- please contact me

History of ☐ Symptoms ☐ Trauma ☐ Resorption ☐ Pulp exposure

- ☐ Other: _____

Access Restoration: *Teeth with temporary restorations will be sealed with an orifice barrier unless otherwise requested*

☐ Restore with temporary ☐ Restore permanently

☐ Leave post space ☐ Other: _____

Current crown is cemented ☐ Permanently ☐ Temporarily

Patient requests: ☐ Nitrous Oxide ☐ Oral Sedation

Additional details: _____

_____

_____

Referring Doctor: _____

Date: _____ Office Phone:_____

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