



CENTER OF ENDODONTICS

— PERIODONTICS AND IMPLANTOLOGY —

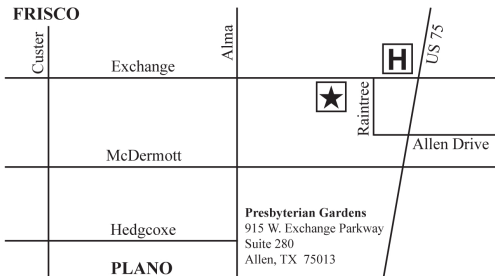
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FRISCO



PLANO

Introducing: _____

Date: _____

Referred By: _____

Endodontic Referral

Patient's Symptoms / Findings (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Hot/Cold Sensitivity | <input type="checkbox"/> Facial Swelling | <input type="checkbox"/> Retreatment |
| <input type="checkbox"/> Biting/Pressure Sensitivity | <input type="checkbox"/> Intentional RCT for Proper Restoration | <input type="checkbox"/> Radiographic Evidence of Periapical Pathology |
| <input type="checkbox"/> Carious Pulp Exposure | <input type="checkbox"/> Pulpotomy | <input type="checkbox"/> Other _____ |

Comments _____

