

ENDODONTICS OF COLORADO, L.L.C

 American Association
 of Endodontics
 Specialist Member

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INTRODUCING _____ Tooth # _____

Appointment Date _____ Time _____

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

- | | | |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Asymptomatic | <input type="checkbox"/> Radiolucency | <input type="checkbox"/> Pulp Exposure |
| <input type="checkbox"/> Percussion | <input type="checkbox"/> Resorption | <input type="checkbox"/> Previous RCT |
| <input type="checkbox"/> Mastication | <input type="checkbox"/> Swelling | <input type="checkbox"/> RCT Initiated |
| <input type="checkbox"/> Temperatures | <input type="checkbox"/> Sinus Tract | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Short | <input type="checkbox"/> Fracture | <input type="checkbox"/> Hx of crack |
| <input type="checkbox"/> Prolonged | | |

Requesting: Eval & Tx Consult Only CBCT Call Before Tx
 Post Space No Cotton Pellet Final Restoration

Pertinent Info:

Referring Dr: _____ Phone _____

Please send more: Referral Pads Business Cards