

BRANTON

ENDODONTICS

Referring Doctor: _____

Date: _____

PATIENT INFORMATION

Patient Name: _____

Patient Phone: _____

PLEASE MARK AREA IN QUESTION

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

ENDODONTIC TREATMENT DESIRED

- ☐ Consultation Only ☐ Apicoectomy (Endodontic Microsurgery) ☐ Other: _____
- ☐ Root Canal Treatment ☐ Root Canal Retreatment _____

RESTORATIVE TREATMENT DESIRED

- ☐ Place Sponge/ Temp Restoration ☐ Leave Post Space
- ☐ Core Build-up (Amalgam or Resin) ☐ Place Post

SYMPTOMS

- ☐ Emergency
- ☐ Symptomatic
- ☐ Asymptomatic

COMMENTS

If possible, please include PA radiograph or BWX.

Referrals can also be submitted through our secure portal on [610endo.com](https://www.610endo.com)