fraservalley endodontics

302-2752 Allwood St.
Abbotsford, BC, V2T 1X9

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Introducing: _____ / _____
First Name Last Name

D.O.B.: _____

Telephone: _____ (home) _____ (cell)

Please evaluate the following tooth/teeth:

1	8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8	2
RIGHT		LEFT
4	8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8	3

1. History

- ☐ Patient has pain/discomfort
- ☐ Recent dental treatment: _____
- ☐ Apical radiolucency
- ☐ Swelling
- ☐ Fracture
- ☐ Pulp exposure
- ☐ Traumatic injury: _____
- ☐ Previous root canal treatment
  - How long ago: _____

2. Treatment administered prior to referral:

- ☐ Occlusal adjustment
- ☐ Root canal treatment has been initiated
- ☐ Incision & drainage
- ☐ Crown/Bridge is cemented
  - ☐ Temporarily
  - ☐ Permanently
- ☐ Rx Antibiotic: _____
- ☐ Rx Analgesic: _____
- ☐ None

3. Treatment to be completed:

- ☐ Consultation/Diagnosis
- ☐ Evaluate and treat as necessary
- ☐ Please leave a post space
- ☐ Please consider non-vital bleaching

4. Radiographs:

- ☐ Being mailed
- ☐ Being emailed
- ☐ Given to patient

Comments: _____

_____

Signed by: _____ Dr.: _____

Date: _____

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CONSULT APPOINTMENT

DATE:

_____

TIME:

_____