

# Skagit Endodontics

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Introducing: \_\_\_\_\_

Home phone number: \_\_\_\_\_

Work phone number: \_\_\_\_\_

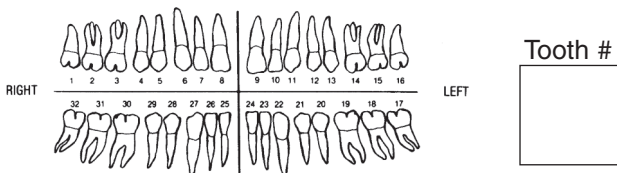
Cell phone number: \_\_\_\_\_

Referred by Dr.: \_\_\_\_\_

Date: \_\_\_\_\_

Insurance Information: \_\_\_\_\_

Appt. Date: \_\_\_\_\_ Time: \_\_\_\_\_



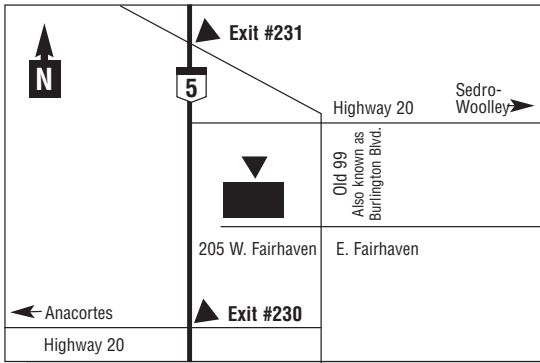
## Pain Symptoms

- Cold Sensitivity       Percussion Sensitivity  
 Heat Sensitivity       Spontaneous Pain  
 Pulp Exposure       Y  N Abnormal Probing  
 O & B Has Been Performed  
 Apical Radiolucency Discovered on Routine Film  
 Failure of Previous Endodontic Treatment
- Date of Original Treatment \_\_\_\_\_
- Post Space       Provide ParaPost       N2O  
Comments/History:       Requires Premedication

**\*PLEASE MAIL OR E-MAIL THIS COMPLETED REFERRAL,  
X-RAY AND INSURANCE INFORMATION TO OUR OFFICE  
PRIOR TO SCHEDULED APPOINTMENT.**

## ***Instructions to Patients***

1. Please call for the first appointment.
2. If your dental treatment is covered by dental insurance, bring the appropriate insurance information with you to the first appointment.
3. Minors should be accompanied by parent or guardian.
4. Endodontic therapy may require more than one visit.
5. Fees are payable upon completion of therapy.



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