SKAGIT
ENDODONTICS

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Patient's Name _____ Date _____

Patient's Phone _____ Patient D.O.B._____

Referring Doctor _____

Appointment Date _____ Time _____

Subscriber_____ D.O.B _____

Insurance Name _____ ID_____

Private Pay ☐

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

Pain Symptoms

☐ Cold Sensitivity ☐ Percussion Sensitivity

☐ Heat Sensitivity ☐ Spontaneous Pain

☐ Pulp Exposure Y N Abnormal Probing

☐ Tooth Previously Opened

☐ Apical Radiolucency Discovered on Routine Film

☐ Failure of Previous Endodontic Treatment ☐ **Requires Premedication**

Date of Original Treatment _____

Temporary ☐ Permanent Restoration ☐ Postspace ☐

Comments/History:

DENTAL OFFICE ONLY

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

Instructions to Patients

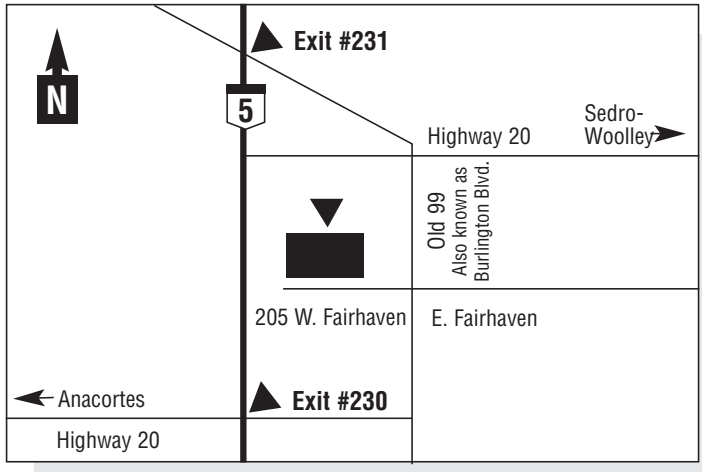
1. Please call for the first appointment.

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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