SOCALDSC™

WESTSIDE ENDODONTICS INC.
Practice limited to ***Endodontics***

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Date _____

PLEASE BRING THIS CARD TO YOUR APPOINTMENT

Patient Name _____

Appointment Date _____ AM PM

Month Day Time

TOOTH NUMBER OR AREA FOR CONSIDERATION

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

☐ Upper Right ☐ Lower Right ☐ Upper Left ☐ Lower Left

Is the tooth treatment planned for a crown restoration? ❑ Yes ❑ No

COMMENTS

_____

_____

_____

_____

SERVICE REQUESTED

☐ Consultation Only
☐ Treat As Needed
☐ Root Canal Treatment
☐ Root Canal Retreatment
☐ Endodontic Surgery
☐ Intentional Endodontics For Restorative Reason
☐ Assist With Diagnosis
☐ Leave Post Space
☐ Place Build-Up
☐ Place Post & Build-Up
☐ Call Prior To Consult/Tx
☐ CBCT Scan
☐ Other:

REFERRING DENTIST _____

OFFICE PHONE NUMBER _____