

Endodontic Referral

Dr. Daniel Kim, DDS—Endodontics Specialist

DATE: _____

REFERRED BY: _____

OFFICE PHONE: _____

Phone: (916) 442-5228
Fax: (916) 448-2801
Email: endo@prodentalmidtown.com
1111 24th Street, #201
Sacramento, CA 95816



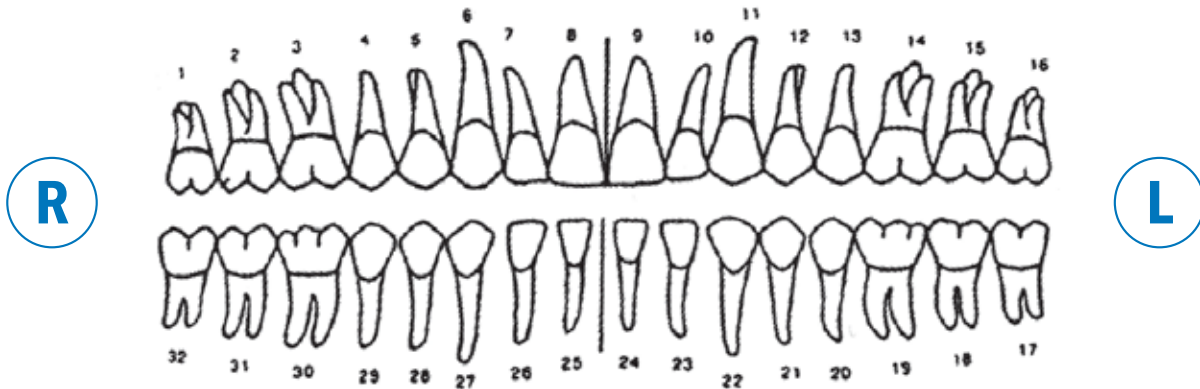
INTRODUCING: _____

BIRTH DATE: _____ PHONE #: _____

APPOINTMENT DATE: _____

TIME: _____ Pt to Call

TOOTH #: _____ Consultation Only Evaluate and Treat as Necessary Initial Retreatment



Please check all that apply:

- Thermal Sensitivity
- Bite Sensitivity
- Swelling
- Radiograph reveals radiolucency
- Pulpal Exposure
- Endodontics Necessary for Restoration
- History of fracture or trauma
- Previous tx appears to be failing
- Patient has vague unlocalized pain in the area indicated

Treatment Requested:

- Create post space

Special Requests/Comments: