

REFERRAL FOR ENDODONTIC EVALUATION

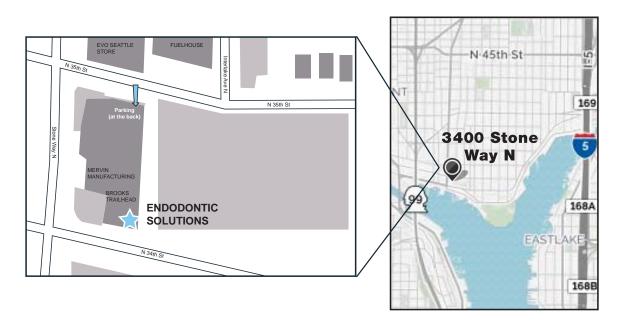
Dr. Carina Lea & Dr. Ben Studebaker

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| Name | | | | | | | | | | Date | | | | | | | | mmen | its/Rec | queste | d Cor | ronal | Rest | ratio | n: |
|------------------------------------|--------|----|-----------|----|----|----------|----|---------------------------|--|---------|-----------|--------|----|--------|----|--|--|------|---------|--------|-------|-------|------|-------|----|
| Daytime Phone Number | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referred By | | | | | | | | | | _Phone | | | | | | | | | | | | | | | |
| Appointment Date | | | | | | | | _ Time | | | | | | | | | | | | | | | | | |
| | Molars | | Bicuspids | | | Anterior | | | | | | ıspids | | Molars | | | | | | | | | | | |
| 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 | | | | | | | | | | |
| Treatment Requested | | | | | | | | | | History | | | | | | | | | | | | | | | |
| ☐ Examine and treat as necessary ☐ | | | | | | | | | Acute symptoms (pain, sensitivity, swelling) | | | | | | | | | | | | | | | | |
| | | | | | | | | ■ Periapical radiolucency | | | | | | | | | | | | | | | | | |
| | | | | | | | | | ☐ Pulp exposure | | | | | | | | | | | | | | | | |
| | | | | | | | | | ■ Tooth has been previously opened | | | | | | | | | | | | | | | | |
| ☐ Surgical crown lengthening ☐ | | | | | | | | 1 Previ | ous end | dodonti | ic treatn | | | | | | | | | | | | | | |
| ☐ CBCT Scan/Kodak 9000 in office | | | | | | | | 1 Other | r | | | | | | | | | | | | | | | | |
| ☐ Permanent filling in access | | | | | | | | | | | | | | | | | | | | | | | | | |

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Patients can log onto our secure website and conveniently complete Patient Registration, Medical History and Pain History online prior to the appointment. Please contact our office for an ID and Password.