



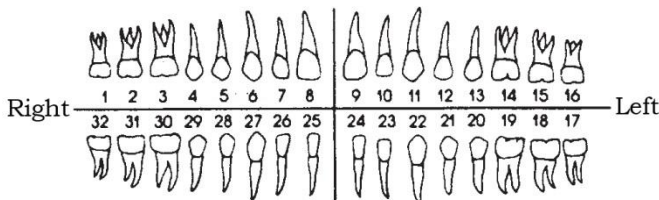
U Village Endodontics

Date: _____ Referred by: _____

Introducing: _____ DOB: _____

Patient contact phone number(s): _____

PLEASE CIRCLE TEETH OR AREA TO BE EVALUATED



TREATMENT REQUESTED:

- Examine & treat as necessary.
- CBCT scan.
- Intentional endodontic therapy.
- Prepare tooth for post.
- Surgical endodontics.
- Internal bleaching.

HISTORY OF:

- Pulp exposure.
- Trauma/fracture/avulsion.
- Tooth previously treated endodontically.

When? _____

Restorative plans for the area: _____

Other helpful information or comments: _____

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