asheville ENDODONTICS

REFERRAL FOR ENDODONTIC EVALUATION

Brandon Chasteen, DMD

Name _____ Date _____

Daytime Phone Number _____

Referred By _____ Phone _____

Appointment Date: _____ Time _____

MOLARS			BICUSPIDS		ANTERIOR						BICUSPIDS		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

- ☐ Root Canal Therapy
- ☐ Examination/diagnosis only
- ☐ Endodontic microsurgery/apicoectomy
- ☐ Prepare post space
- ☐ CBCT Scan
- ☐ Permanent filling in access

HISTORY

- ☐ Acute symptoms (pain, sensitivity, swelling)
- ☐ Periapical radiolucency
- ☐ Pulp exposure
- ☐ Tooth has been previously opened
- ☐ Previous endodontic treatment
- ☐ Other _____

COMMENTS/REQUESTED CORONAL RESTORATION:

201 East Chestnut St. Ste. A, Asheville, NC 28801 • ashevilleendo.com • Ph: 828.251.0300 • Fx: 828.251.0484