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Introducing:____

Phone:______________________ Email:______________________

Appointment Date: ______________Time: ______________ AM/PM

❑ Please evaluate and treat. ❑ Please evaluate only.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	UPPER
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LOWER

RIGHT LEFT

Tooth pain is felt with ❑ Cold ❑ Hot ❑ Percussion ❑ Chewing/Biting

❑ Sinus Tract/Fistula
❑ X-ray reveals radiolucency
❑ Tooth history of crack/fracture
❑ Pulp was exposed (or possibly exposed)
❑ RCT is necessary for restoration
❑ Orofacial Swelling
❑ Tooth was opened and temporized
❑ Tooth needs internal bleaching
❑ Patient has vague non-localized pain in area indicated
❑ CBCT Evaluation

Please place the following restoration in access opening:
❑ Temporary ❑ Composite ❑ Post & Core ❑ Amalgam

Requests or concerns: ____

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Referred by Dr______________________________ Date ______________

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.

Specialist Member

Patient Information:

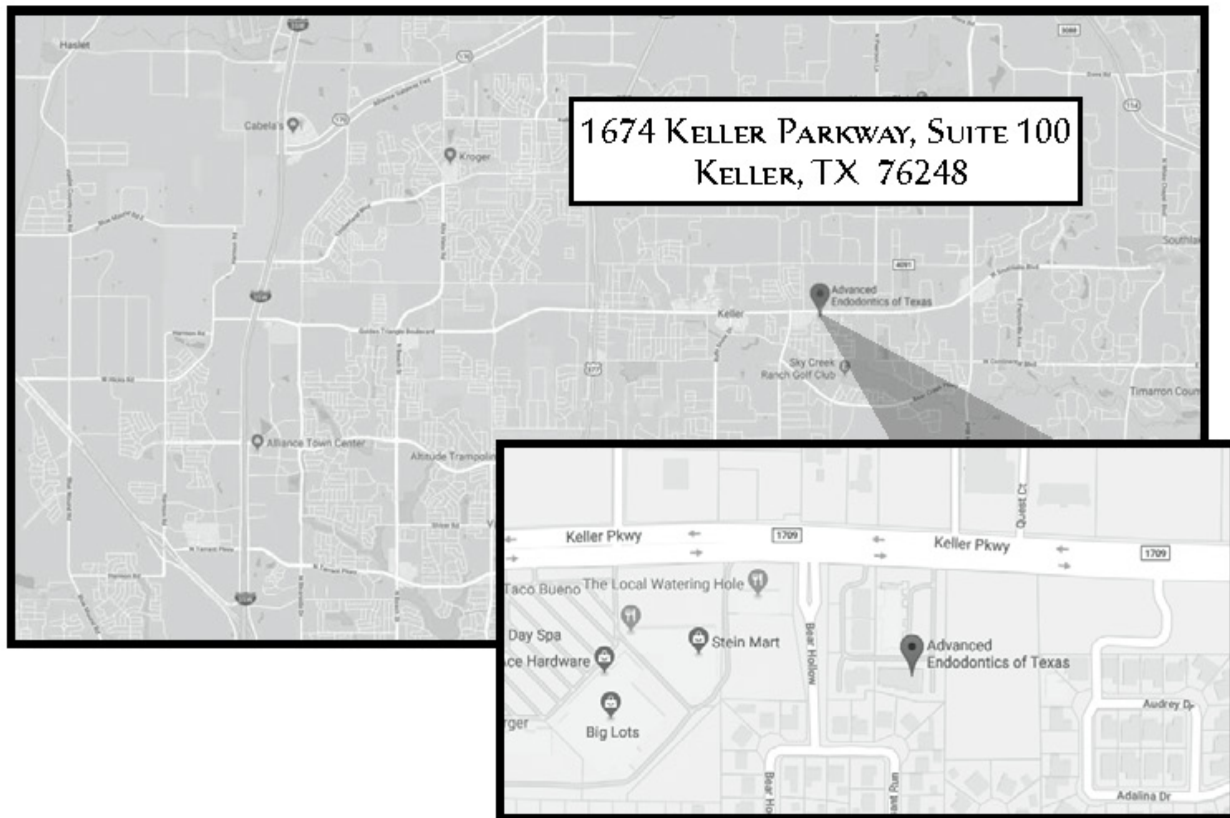
Advanced Endodontics of Texas

Please bring with you to your visit:

- This referral form
- Dental insurance information and form of payment
- List of medications

Please visit our website to:

- Learn more about your visit and our office
- Complete your Registration – Please contact our office for an ID and Password.



Advanced Endodontics of Texas

Please contact our office if you have any questions or concerns about your visit

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