INTRODUCING: _____
name

Appointment _____
day *date* *time*

☐ Evaluate and treat tooth or area(s) _____

☐ Root Canal Treatment

☐ Retreatment of previous Root Canal

☐ Apicoectomy / Retrograde

☐ Periodontal crown lengthening request

☐ Post and core request

☐ Post space request

☐ I.V. Sedation requested

☐ Oral Sedation

☐ Implant Consultation

☐ Please contact Referring Doctor immediately: _____

☐ Medical considerations: _____
telephone

☐ Comments: _____

_____

_____

☐ Referring Doctor _____
date

Dear Patient,

Our specialty office would like to welcome you as a patient. You will find us concerned and uniquely skilled to serve you.

Your dentist has already advised you that you may have a tooth and/or a bony endodontic (root canal) problem. Your initial visit to our office will consist of a thorough examination and discussion of the findings and options with you. If you are in acute pain, emergency pain relieving treatment will be initiated. Plan about one hour of your time for this visit.

Your initial visit will also include a financial consultation to facilitate your payment for specialty services. Please bring your insurance information/ID card, forms, etcetera.
If you wish you may bring your spouse or a close family member along to listen to the consultation.

We look forward to meeting you.

☐

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☐

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☐

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☐

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