CAPITAL ENDODONTICS

Specialists in Root Canal Treatments & Microsurgery

Referring to:
- ☐ First Available Appointment
- ☐ Dr. Mike Thompson, DDS, MSc., FRCD(C)
- ☐ Dr. John N. Odai, DMD, MSD, FRCD(C), FICD
- ☐ Dr. Dr Rachele Luciano, DMD, FRCD(C), Cert. Endo, Diplomate ABE

Patient: (Name)

(Email Address)

Telephone: (Res.) (Bus.) (Mobile)

Referring Doctor: (Name) (Dental Clinic)

(Email Address) (Bus.)

Date Referred: (MM/DD/YYYY)

- ☐ Sensitivity to Cold/Hot
- ☐ Pain to Biting/ Pressure
- ☐ Severe Pain/ Swelling
- ☐ Possible Fracture
- ☐ Elective Endodontics
- ☐ IV Sedation
- ☐ Apical Surgery
- ☐ CBCT
- ☐ Emailed Current/ Pre-treatment Radiographs

Post space required? ☐ Yes ☐ No

R	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	L
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Please circle Tooth/Teeth requiring treatment

Comments (Significant Medical/Dental History, etc.): _____

PLEASE NOTE: At least three radiographs will be taken at your consultation appointment.

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