

*Committed To Excellence  
Through Personalized Care*

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- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Kenneth G. Whitnack, D.D.S., M.S. | <input type="checkbox"/> Kevin M. Keating, D.D.S., M.S. | <input type="checkbox"/> Kathleen J. Greene, D.D.S. |
| <input type="checkbox"/> Aneet S. Bal, D.D.S.              | <input type="checkbox"/> Sheri A. Opp, D.D.S., M.S.D.   | <input type="checkbox"/> David M. Keating, D.D.S.   |

**SACRAMENTO**

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**WOODLAND**

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**ROCKLIN**

2203 Plaza Dr., Suite 100  
Rocklin, CA 95765  
916/626-3010  
fax 916/783-1188

**Appointment date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient Phone \_\_\_\_\_

Referring Doctor \_\_\_\_\_

**Please circle tooth or area to be evaluated:**

**TOOTH INVOLVED**

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

- HISTORY**
- |  |   |
|--|---|
| <input type="checkbox"/> Pain                  | <input type="checkbox"/> Pulp Exposure      |
| <input type="checkbox"/> Apical Radiolucency   | <input type="checkbox"/> Trauma             |
| <input type="checkbox"/> Swelling              | <input type="checkbox"/> Prior Root Canal   |
| <input type="checkbox"/> Fracture              | <input type="checkbox"/> Recent Filling     |
| <input type="checkbox"/> Periodontal Condition | <input type="checkbox"/> Subgingival Caries |

- Treatment You Have Performed**
- Occlusion adjusted
  - Sedative dressing placed
  - Pulpectomy
  - Incision/drainage
  - Rx Antibiotic \_\_\_\_\_
  - Rx Analgesic \_\_\_\_\_
  - None

- TREATMENT PERFORMED IN THE ENDODONTIC OFFICE**
- |  |  |
|--|--|
| <input type="checkbox"/> Consultation/diagnosis only | <input type="checkbox"/> Leave post space                        |
| <input type="checkbox"/> Root canal treatment        | <input type="checkbox"/> Permanent restoration in access opening |

**REFERRING DOCTOR'S COMMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_