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**Please bring this referral to your appointment.**

**SACRAMENTO**

1810 Professional Dr., Ste. A  
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**ELK GROVE**

9309 Office Park Cir., Ste. 100  
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**ROSEVILLE**

568 N. Sunrise Ave., Ste. 300  
Roseville, CA 95661  
916-626-3010  
fax 916-783-1188

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

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

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

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

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

**Referring Doctor's Comments and Clinical Information:**

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

**History**

- Pain
- Apical Radiolucency
- Swelling
- Fracture
- Periodontal Condition
- Pulp Exposure
- Trauma
- Prior Root Canal
- Recent Filling
- Subgingival Caries

**Restorability Concerns**

**Treatment You Have Performed**

- Occlusion adjusted
- Sedative dressing placed
- Pulpectomy
- Incision/drainage
- Rx Antibiotic \_\_\_\_\_
- Rx Analgesic \_\_\_\_\_
- None

**Treatment to be Performed in the Endodontic Office**

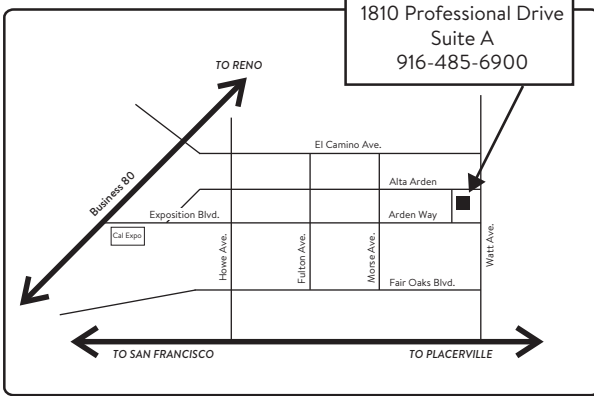
- Consultation/diagnosis only
- Root canal treatment
- Leave post space
- Permanent restoration in access opening

**Referring Doctor Signature**

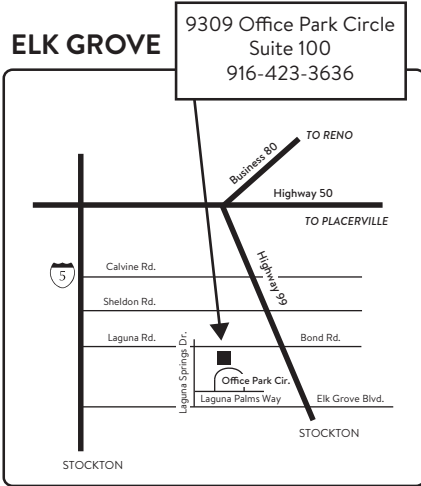
Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_

— MAPS NOT TO SCALE —

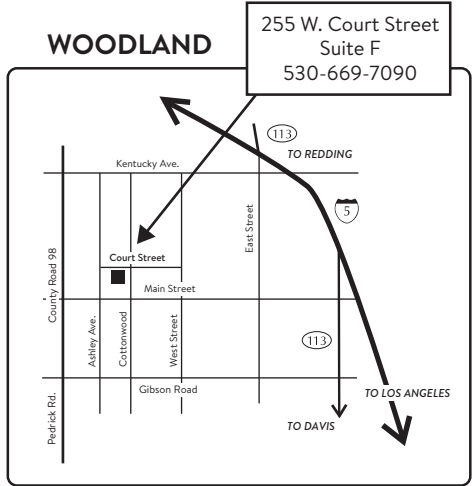
### SACRAMENTO



### ELK GROVE



### WOODLAND



### ROSEVILLE

