ENDODONTIC ASSOCIATES DENTAL GROUP

www.endofiles.com

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Please bring this referral to your appointment.

☐ **SACRAMENTO**
1810 Professional Dr., Ste. A
Sacramento, CA 95825
916-485-6900
fax 916-485-0102

☐ **ELK GROVE**
9309 Office Park Cir., Ste. 100
Elk Grove, CA 95758
916-423-3636
fax 916-683-2115

☐ **WOODLAND**
255 W. Court St., Ste. F
Woodland, CA 95695
530-669-7090
fax 530-669-7095

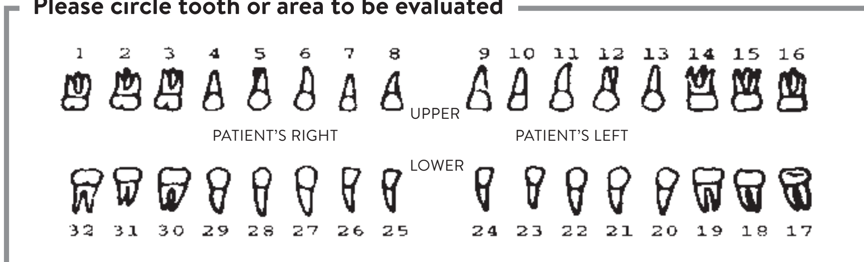
☐ **ROSEVILLE**
568 N. Sunrise Ave., Ste. 300
Roseville, CA 95661
916-626-3010
fax 916-783-1188

Appointment date: ____________________ **Time:** ______________

Patient Name ________________________ Patient Phone ______________

Referring Doctor____

Please circle tooth or area to be evaluated



Referring Doctor's Comments and Clinical Information:

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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

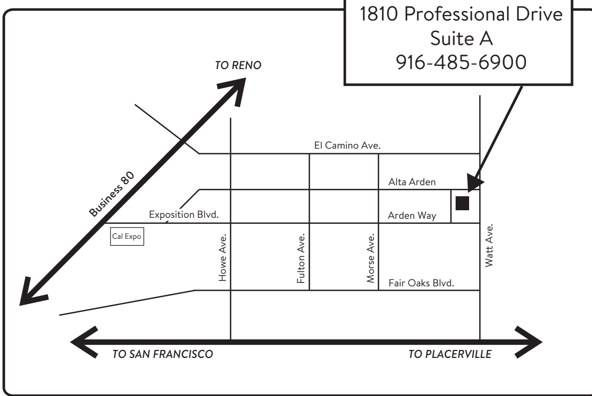
Referring Doctor Signature

Dr. Signature______________________________ **Date** ______________

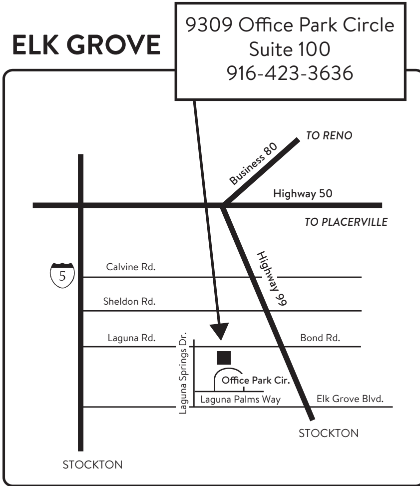
See back side of this sheet for a map to our offices.

— MAPS NOT TO SCALE —

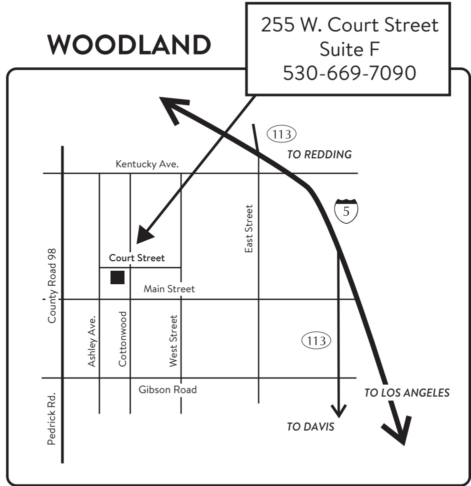
SACRAMENTO



ELK GROVE



WOODLAND



ROSEVILLE