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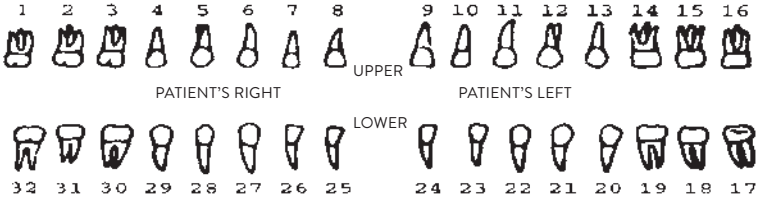
☐ **ROSEVILLE**
568 N. Sunrise Ave., Ste. 300
Roseville, CA 95661
916-626-3010
fax 916-783-1188
roseville@endofiles.com

Appointment date: _____ **Time:** _____

Patient Name _____ Patient Phone _____

Referring Doctor_____

Please circle tooth or area to be evaluated



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

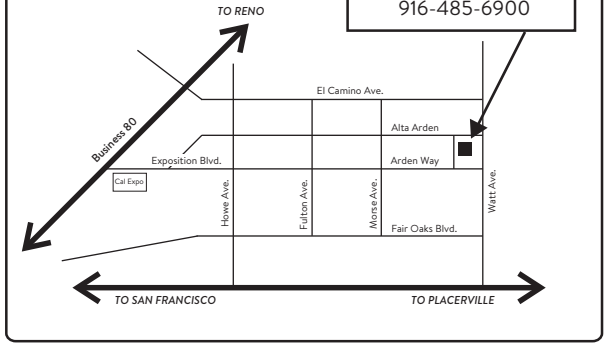
Dr. Signature_____ **Date** _____

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

— MAPS NOT TO SCALE —

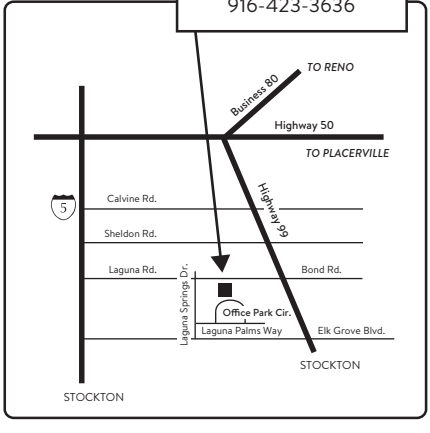
SACRAMENTO

1810 Professional Drive
Suite A
916-485-6900



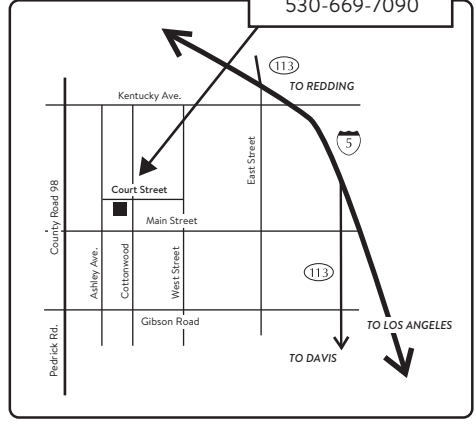
ELK GROVE

9309 Office Park Circle
Suite 100
916-423-3636



WOODLAND

255 W. Court Street
Suite F
530-669-7090



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