PROFESSIONAL ENDODONTICS
OF ILLINOIS

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Date: _____

Introducing: _____

Appointment Date: _____ **Time:** _____

Referring Doctor: _____ **Phone:** _____

Instructions: _____

_____

To Be Filled In By Dentist:

- ☐ **Patient is having pain, swelling, sensitivity. Please Evaluate.**
- ☐ **Endodontic treatment is necessary for proper restoration of tooth.**
- ☐ **Nerve was exposed.**
- ☐ **X-Ray revealed radiolucency.**
- ☐ **Root Canal tratment was started.**
- ☐ **Post prep is indicated.**
- ☐ **Evaluation for possible apical surgery.**
- ☐ **Retreatment.**

	Molars			Right Bicuspids		Anteriors			Anteriors			Left Bicuspids		Molars		
Upper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Lower	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

(circle teeth for endodontic consideration)

Information for Patient:
- You will be returning to your family dentist for final restoration after treatment.
- When calling for your appointment, please have your dental insurance information available.
- Please bring your dental insurance information to your appointment.


83
Prospect Heights
Elmhurst Rd
Rand Rd
Mt Prospect
12
Northwest Hwy
14
Golf Rd
W Golf Rd
Elmhurst Rd
Rand Rd
Miner St
21
Milwaukee Ave
N River Rd
45
INTERSTATE
294
Tri-State Tollway (Toll road)
INTERSTATE
294
Des Plaines
INTERSTATE
294
Lee St
Mannheim Rd
Touhy Avenue
INTERSTATE
90
Jane Addams Memorial Tollway (Toll road)
Elmhurst Rd
72
Higgins Rd