



PROFESSIONAL ENDODONTICS

OF ILLINOIS

www.ProfEndoIllinois.com

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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 treatment was started.
- Post prep is indicated.
- Evaluation for possible apical surgery.
- Retreatment.
- CBCT

	Molars			Right Bicuspid		Anteriors			Anteriors			Left Bicuspid		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.

IN NETWORK WITH ALL PPO PLANS

