



METROPOLITAN ENDODONTICS

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Introducing _____

Date of Birth _____

☐ Pain ☐ Radiolucency ☐ Previous RCT ☐ Resorption

☐ Swelling ☐ Pulp exposure ☐ History of crack

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

Referred by Dr. _____

Appointment date/time _____

☐ Burnsville ☐ Eden Prairie ☐ Inver Grove Heights ☐ Woodbury

Requests:

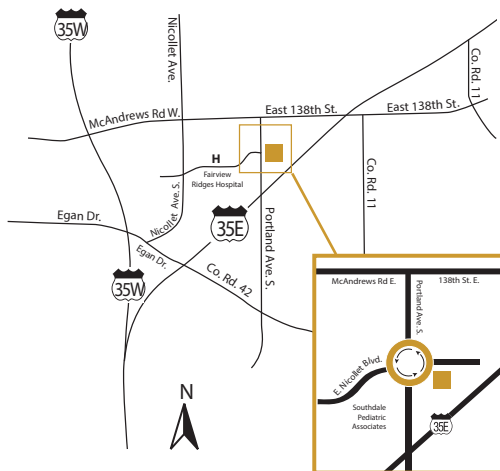
- ☐ Evaluate and treat
- ☐ Inconclusive findings.
Additional testing needed to confirm diagnosis
- ☐ Evaluate only
- ☐ Endodontic treatment necessary for proper restoration
- ☐ Endodontic treatment initiated.
- ☐ Post Space

Remarks: _____

- ☐ Temporize and return for restoration
- ☐ Restore access with:
 - ☐ Discretion of Endodontist
 - ☐ Composite ☐ Amalgam

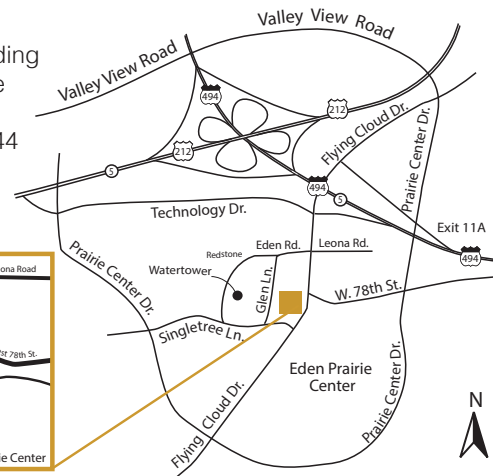
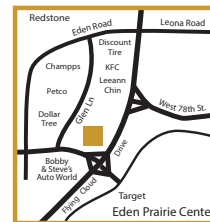
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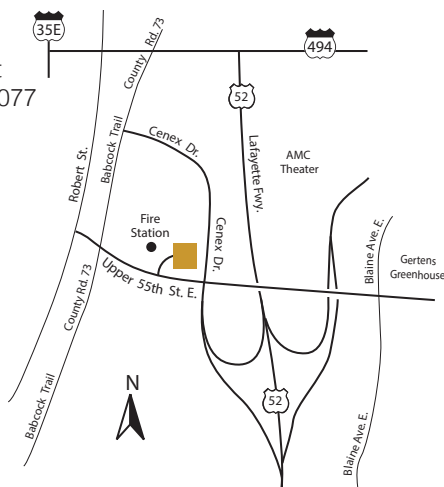
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