Apex Endodontics

Patient Name: _____

Phone: _____ **Email:** _____

Referring Dr: _____ **Office:** _____

☐ **Please contact patient** ☐ **Patient was instructed to contact your office**

REASON FOR REFERRAL:

- ☐ Carious pulp Exposure
- ☐ Periapical pathosis
- ☐ Pain/Irreversible pulpitis
- ☐ Retreatment of previous RCT
- ☐ RCT required for restorative reasons

PLEASE CIRCLE TEETH INVOLVED:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R			A	B	C	D	E	F	G	H	I	J			L
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

AFTER ENDODONTIC REFERRAL:

- ☐ Temporary only
- ☐ Buildup for crown
- ☐ Permanent restoration on existing crown access
- ☐ Post/Core Build up
- ☐ Leave post space of _____ mm

ADITIONAL COMMENTS:

_____

_____

_____

Please email completed form, medical history, insurance info and x-rays to **info@apexendotx.net**

20631 Kuykendahl Rd, Suite 140
Spring, TX 77379
281-655-0603
www.apexendotx.com