

# encinitas endodontic specialists

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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Phone #s H \_\_\_\_\_ W \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Patient will call

Please call patient

My appointment

Date \_\_\_\_\_

Time \_\_\_\_\_

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

Circle tooth / area

## ABOUT THE TOOTH:

SYMPTOMATIC

ASYMPTOMATIC

PRIOR RCT

## REFERRED FOR:

Endodontic Treatment as needed

Endodontic Re-treatment

Surgical Endodontics

Perforation Repair

Internal (Non-surgical)

External (Surgical)

Removal of

Post

Separated Instrument or Bypass

## ADDITIONAL:

Pulp Exposure - treat as needed

Endodontics Requested for Restoration

Root Fracture Analysis

Post Space

Post & Core Build-up

Place Final Restoration

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## INSTRUCTIONS TO PATIENTS

Please call for an appointment.

If you are taking medications please bring them with you

Minors must be accompanied by a parent or guardian.

Fees are payable during or upon completion of therapy.

E-mail Report to Referring Doctor at: \_\_\_\_\_

e-mail address

WHITE - Give to Patient

YELLOW - Keep in YOUR Patient Chart



American Association of Endodontists  
Specialist Members

