ENDODONTICS
OF WICHITA COUNTY

Endodontics of Wichita County
Microscopic & Microsurgical Root Canal Therapy
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Diplomate, American Board of Endodontics

Endodontic Referral Form

Date:_____

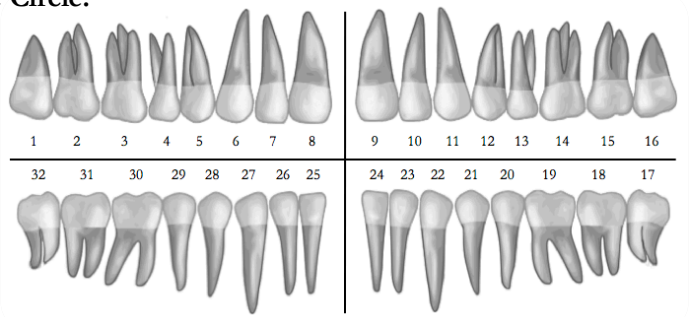
Patient:_____ Patient DOB:_____

Patient Phone:_____ Patient Email:_____

Referred by:_____

Appt. Date:_____ Time:_____

Please Circle:



Status of the Tooth:

- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Previous endodontic treatment is failing
- ☐ Fractured tooth/restoration
- ☐ Emergency treatment was preformed

Recent Treatment:

- ☐ Restoration/temporary
- ☐ Crown/temporary
- ☐ Pulp cap
- ☐ Pulpotomy
- ☐ Periodontal Treatment

Endodontic Procedures Requested:

- ☐ Evaluate and treat as necessary
- ☐ Evaluate only/consult Doctor before proceeding
- ☐ Non-surgical evaluation and treatment
- ☐ Prepare POST SPACE
- ☐ Restore access with
  - ☐ Temporary
  - ☐ Permanent filling

Remarks:_____

_____

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