SISKIYOU ENDODONTICS

R Kai Reynolds, DDS, MSD

siskiyouendo@gmail.com • www.siskiyouendo.com
phone: 541.482.9654 fax: 866.850.4790

☐ **Medford** • 691 Murphy Rd, #204 • Oregon 97504
☐ **Ashland** • 254 Palm Ave • Oregon 97520

Referring Doctor:______________________________ Today's Date:__________

Patient Name:____

Appt. Day, Date:____________________ Appt. Time:____________________ ☐ AM ☐ PM

CIRCLE TEETH FOR ENDODONTIC CONSIDERATION

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

TO BE COMPLETED BY DENTIST

TREATMENT REQUESTED

☐ Examination and diagnosis only

☐ Examine and treat as needed

FINISHING TREATMENT REQUEST

☐ Provisional restoration

☐ Permanent access restoration

☐ Build-up restoration

☐ Please leave space for post-prep

Comments:____