SISKIYOU ENDODONTICS

"It's a beautiful day for a root canal."

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3549 Lear Way, Suite 105 • Medford • Oregon 97504

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:_____

PATIENT INFORMATION

1. Patient should return to referring dentist for final restoration of the tooth after root canal treatment is complete.
2. If problems should arise prior to your appointment, please call our office, **541.482.9654**.
3. If you are using dental insurance, please bring necessary information with you.
4. If you are unable to keep your appointment, call our office with at least 24 hours notice, so the reserved time may be used by another.
5. Minors must be accompanied by a parent or legal guardian at the time of consultation and treatment, unless prior arrangements have been made.