Prime Endodontics

Your root canal specialist

Specialist Member

Keyvan Lazar, DDS

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Introducing _____

Referred by Dr. _____

Dr. Phone No.: _____ Date: _____

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

(Cirrcle teeth for endodontic consideration)

Tooth by name: _____

Please evaluate and perform the following:

- ❑ Consultation and Diagnosis Only
- ❑ Root Canal Treatment
- ❑ Root Canal Retreatment
- ❑ Consult and Treat as Necessary
- ❑ Intentional Endo
- ❑ Surgical Endodontics
- ❑ Internal Bleaching

If exists, is the crown restoration going to be replaced?

❑ Yes ❑ No ❑ If necessary

The following procedures are not routinely done unless requested.

- ❑ Prepare Post space.
- ❑ Place build-up or post & build-up
- ❑ Others _____

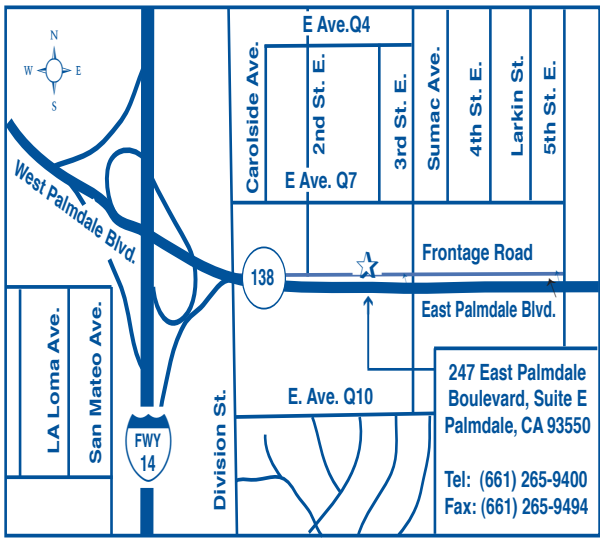
Comments/Special Instructions

_____

_____

_____

_____



Appointment

_____

Day Date Time

Instruction to Patient

- Please call for the first appointment.
- If your dental treatment is covered by dental insurance, bring the appropriate insurance forms with you to the first appointment.
- Minors should be accompanied by parent or guardian.

Please bring this slip with you. Thank you.