ACE | Advanced Clinical Endodontics

HEIGHTS

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Date: _____

Patient Name: _____ DOB: _____ Phone Number: _____

Referred by Dr.: _____ Office Number: _____

Pending Claims: $ _____

Referred For Tooth/Teeth #: _____

Upper

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

Lower

Reason For Referral

- ☐ Consultation
- ☐ Root Canal Treatment
- ☐ Re-Treatment
- ☐ Root Canal Treatment for Restorative Purposes
- ☐ CBCT Scan only
- ☐ Apicoectomy
- ☐ Internal Bleaching

Access Closure

- ☐ Temporary Filling
- ☐ Core Buildup
- ☐ Leave Post Space
- ☐ Post + Core Buildup

Other Considerations

- ☐ Possible Fracture
- ☐ Concerns About Restorability
- ☐ Pre-Medicate
- ☐ Sedation

May we reduce the occlusion? Yes ☐ No ☐

Comments: _____

_____

_____

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