Experienced in Care...Skilled in Service

Donald L. Kelley, D.D.S., M.S.

Dave E. Eccker, D.M.D.

Endodontic Specialists

ENDODONTIC CENTER OF LEXINGTON PLLC

PATIENT NAME: _____

APPOINTMENT DATE: _____ TIME: _____

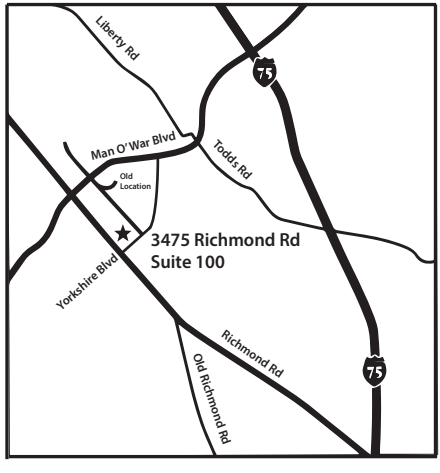
Patient is being referred for the following:

☐ Consult ☐ Root Canal Therapy ☐ Retreatment

Tooth# _____

TREATMENT HISTORY:

- ☐ Deep Filling or Pulp Cap
- ☐ Pulp Exposure
- ☐ Pulpotomy Done Date: _____
- ☐ Previous Root Canal Treatment



FINDINGS:

- ☐ Radiolucency
- ☐ Pressure Sensitive
- ☐ Temperature Sensitive
- ☐ Trauma History
- ☐ Possible Fracture
- ☐ Asymptomatic

SPECIAL NEEDS:

☐ Post Space ☐ Premedication ☐ Latex Allergy

PLANNED RESTORATION:

☐ CROWN ☐ BRIDGE ☐ FILLING

COMMENTS: _____

_____

REFERRED BY DR: _____ DATE: _____

PHONE: _____

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AAE SPECIALIST MEMBER