RENTON ENDODONTICS

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Tom H. Wei, DDS MS

Date: _____

Name: _____ DOB: _____

Pt Phone: _____ Referred by: _____

Insurance _____ Mem ID: _____

Evaluate Tooth #_____

- ☐ Consultation only
- ☐ Consult + endodontic therapy
- ☐ Consult + retreatment
- ☐ Consult + apicoectomy

Restorative Instructions

- ☐ RCT required for restoration
- ☐ Place build-up
- ☐ Leave post space
- ☐ Place temporary restoration

Dental History:

- ☐ Previous root canal
- ☐ Pain and/or swelling
- ☐ Radiographic lesion
- ☐ Pulp exposure

Treatment Performed:

- ☐ Root canal Initiated
- ☐ Recent restoration
- ☐ Antibiotics prescribed
- ☐ Pain medication prescribed

Radiographs:

- ☐ Sent by email/mail
- ☐ Given to patient
- ☐ Take at consult

Sedation:

- ☐ Nitrous oxide
- ☐ Oral anxiolytic sedatives

Comments: _____

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10700 SE 174th St. Unit 102, Renton WA 98055

Please email or fax referral form to 425-276-0098 or info@rentonrootcanals.com