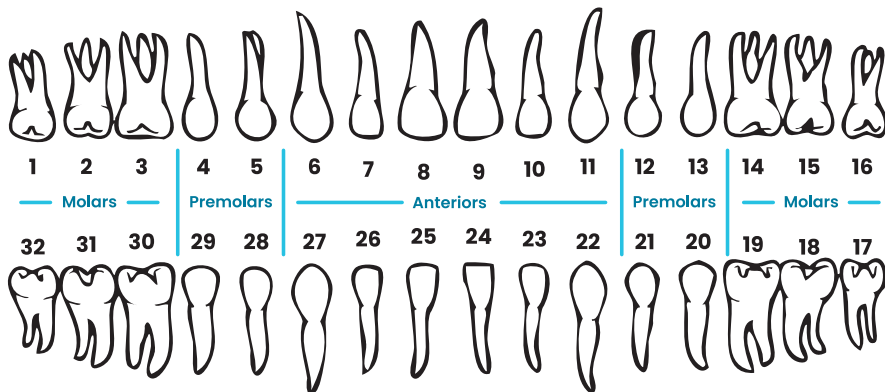




Introducing Patient: _____

For Endodontic Evaluation of the Following Tooth/Teeth



Service Requested

- ☐ Evaluate & Treat ☐ Evaluate Only ☐ Surgical RCT ☐ Bleaching
- ☐ CBCT Imaging ☐ IV Sedation ☐ Nitrous Oxide ☐ Other _____

Status/Reason

- ☐ Pulp Exposure ☐ Previous Endodontic Treatment ☐ Elective Endodontics For Restorative Purposes ☐ Radiographic Finding
- ☐ Symptomatic ☐ Other _____

Desired Restoration

- ☐ Temporize ☐ Prepare Post Space ☐ Restore Endodontic Access
- ☐ Other _____

Comments: _____

Referring Doctor: _____ Date: _____



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ENDODONTIC CARE

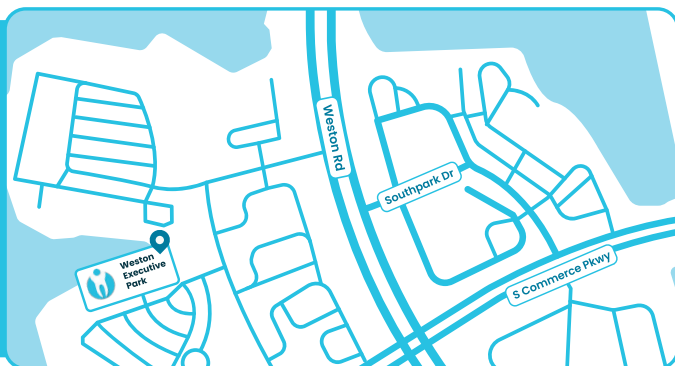
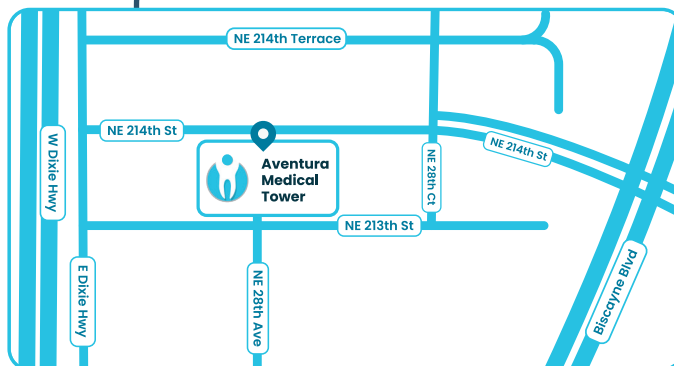
(305) 454-9237 – (954) 800-3453

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Lauren Tink, DMD, Cert (Endo), Dip ABE
Karina Leiva, DMD, Cert (Endo), Board Eligible

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Board Eligible

Your referral is the greatest endorsement.

Thank you for your confidence and partnership.