MASON BAHADOR D.D.S.
ENDODONTIST

Patient: _____

Patient phone number: _____

Referred by: _____

Referral date: _____

UPPER

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT																	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

LOWER

☐ Evaluation as needed
☐ Evaluation only/consult with Doctor before treatment
☐ Root canal treatment
☐ Retreatment RCT
☐ IV Sedation

Does the tooth have a crown ? Yes / No

☐ Provisional ☐ Permanent

Cemented temporarily or permanently? _____

Post space? Yes / No

CBCT Scan: Yes / No

Comments: _____

_____

Appointment Day/Time: _____

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