WATERFRONT
ENDODONTICS

TRAVIS CHAPMAN, DMD

APPOINTMENT

DAY DATE TIME

Please see back for instructions.

Introducing _____

Referring Dr. _____

Dr. Phone # _____ Date _____

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

Please circle teeth for endodontic consideration.

Tooth by Name _____

Please evaluate and perform the following:

- ❑ Consultation & Diagnosis Only
- ❑ Root Canal Treatment
- ❑ Root Canal Retreatment
- ❑ Consult & Treat as Necessary
- ❑ Intentional Endo
- ❑ Surgical Endodontics
- ❑ Internal Bleaching
- ❑ Other _____

If exists, is the crown restoration going to be replaced?

❑ Yes ❑ No ❑ If Necessary

The following procedures are not routinely done unless requested.

- ❑ Prepare Post Space
- ❑ Place Build-up or Post & Build-up
- ❑ Others _____

Comments/Special Instructions

_____

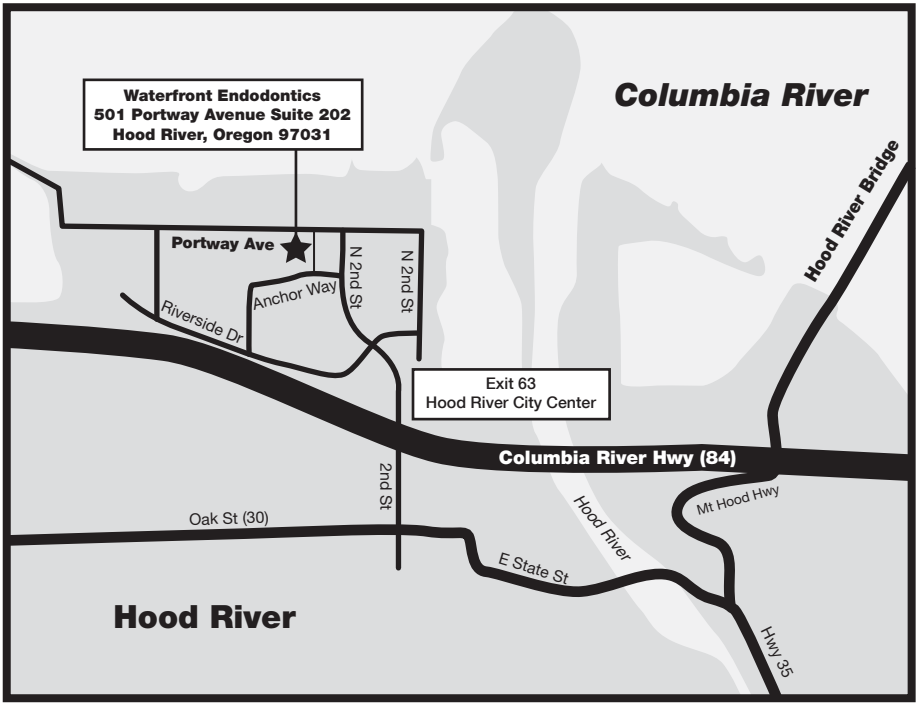
_____

_____

(541) 436-2740 • www.WaterfrontEndo.com

INSTRUCTIONS TO PATIENT

- Please call **(541) 436-2740** for your first appointment.
- If your dental treatment is covered by dental insurance, bring the appropriate insurance forms to your first appointment.
- Minors should be accompanied by a parent or guardian.
- ***Please bring this slip to your appointment.***



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