ACCESS ENDODONTICS
PRACTICE LIMITED TO ENDODONTICS

John S. Lee, DMD, MS

Date _____

Patient Name _____

Phone _____

PLEASE PLACE AN X ON THE INVOLVED TOOTH / TEETH

R	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

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REASON FOR REFERRAL

- ☐ Patient is Symptomatic
- ☐ Previous Root Canal
- ☐ Tooth has been previously opened
- ☐ Other _____

TREATMENT REQUESTED

- ☐ Consult
- ☐ Root Canal
- ☐ Retreatment
- ☐ Endodontic Surgery

Repair Access With:

- ☐ Sponge and Cavit
- ☐ Composite
- ☐ Core Build Up
- ☐ Post Space Only
- ☐ Post and Core

Other _____

Comments _____

PLEASE **EMAIL** or **FAX** COMPLETED FORM TO office@accessendodfw.com or Fax **972.304.7945**

CONTACT INFORMATION

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APPOINTMENT INFORMATION

Date _____

Day _____

Time _____

Referred by _____