



Endodontic Specialists, P.C.

Samuel R. Epley, D.M.D. Erik F. Zorn, D.D.S., M.S. Erik D. DeYoung, D.D.S., M.S.

(517) 351-0800
FAX: (517) 580-3103

www.lansingrootcanal.com
info@lansingrootcanal.com

TODAY'S
DATE _____

THIS IS TO INTRODUCE _____ DOB: _____
(MINORS MUST BE ACCOMPANIED BY A PARENT OR GUARDIAN)

PLEASE BRING THIS REFERRAL FORM TO YOUR APPOINTMENT.

APPOINTMENT ON _____ AT _____ AM/PM

<input type="checkbox"/> CENTRAL 2501 COOLIDGE RD. #201 EAST LANSING, MI 48823	<input type="checkbox"/> WEST 6105 W. ST. JOSEPH #203 LANSING, MI 48917
---	--

SEE REVERSE FOR MAP

**PLEASE LET US KNOW AT THE TIME OF SCHEDULING IF THE PATIENT IS PREGNANT
OR IF ANTIBIOTIC PREMEDICATION IS NECESSARY**

**** BRING A LIST OF ALL MEDICATIONS TO YOUR APPOINTMENT ****

TOOTH NUMBER(S) _____

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

REFERRED BY _____ PHONE # _____

PLEASE CHECK ALL THAT APPLY:

REFERRED FOR ENDODONTIC

- DIAGNOSIS ONLY
(TO DETERMINE IF TREATMENT IS NECESSARY)
- EVALUATION AND TREATMENT
- RETREATMENT/PERIAPICAL SURGERY
(WILL REQUIRE A SEPARATE EVALUATION APPOINTMENT FIRST)

TREATMENT REQUESTS:

- PARA POST
- CAST POST

CONSIDERATION:

- CRACKED TOOTH
- PULP EXPOSED
- RESORPTION

COMMENTS _____

PATIENT WILL BE INSTRUCTED TO RETURN TO GENERAL DENTIST FOR FINAL RESTORATION.

