Microsurgical Endodontics

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Practice Limited to Endodontics
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Patient Name: _____

Appt Date/Time: _____

Referred by Dr. _____

Please schedule for Endodontic Treatment

Tooth # _____

Reason for treatment:_____
_____
_____
_____
_____
_____

Please Schedule Endodontic Evaluation

❑ Vague/nonlocalized pain or sensitivity

❑ Tooth has had previous endodontic treatment

Remarks: _____
_____
_____
_____
_____

Patients please bring the following to your appointment:

1. This referral slip & X-rays from your dentist
2. A list of all current medications you are taking & the reason for taking them
3. If you have dental insurance, please bring your DENTAL INSURANCE card with you

Please do not take any pain medications 8 hours prior to your appointment.

You may download Registration forms online to complete prior to your appointment at www.ohioendo.com/patient-registration

Payment is expected at the time of service unless arrangements are made prior to your appointment

825 HIGH STREET IN OLD WORTHINGTON