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Fariborz Farsio D.D.S.
Practice Limited to Endodontics



Date ___/___/___ Introducing _____ Referred By Dr. _____
GP Email: _____

Please circle tooth or teeth for endodontics considerations:

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

- Consultations and Diagnosis
- Pulp was exposed (vital / nonvital)
- Radiolucency and / or pulpal involvement noted
- Patient has (had) pain /swelling or sensitivity
- Please evaluate and treat as necessary
- Endodontics necessary for proper restoration
- Final Restoration
 - Prepare Post Space
 - Place Post and Build Up

- Other Findings or remarks _____
- Analgesic prescribed _____
- Antibiotics prescribed _____

Appointment Scheduled For:

Date _____ Time _____

Please do not take any pain medications prescribed by your dentist 6 hours before consultation / exam.

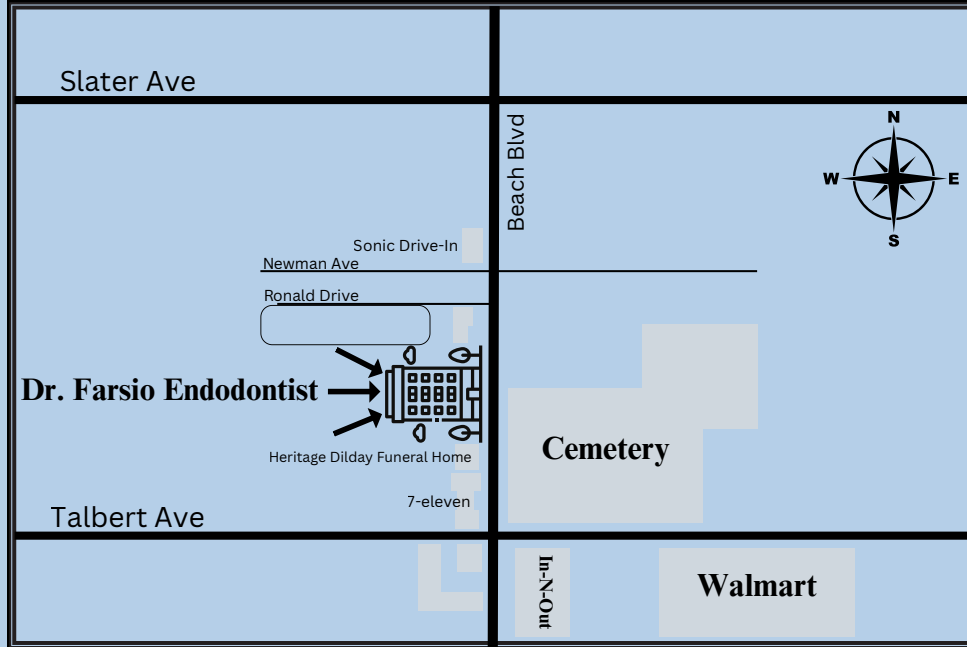
Please arrive 15 minutes early to fill out paperwork.

O.C. SPECIALTIES
ENDODONTICS
DENTAL GROUP

GentleWave
PROCEDURE



 **oc_specialtydental**



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