

ADVANCED ENDODONTICS

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Patient Name: _____ Date: _____

Patient Phone: _____ Patient D.O.B.: _____

Appt. Date: _____ Time: _____

Referred by: Dr. _____ Office Ph: _____

Consult first Consult and Treatment

Please call patient Patient will call

Radiographs emailed: Office@DrScottBarry.com

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 INDICATE A RESTORATIVE DIRECTIVE.

Note: All teeth to be temporized will have an orifice barrier placed unless otherwise directed.

Temporary Only:

(Returning to General Office for Final)

Cotton/Cavit

Cotton/IRM

Cotton/Glass Ionomer

Leave post space

Permanent Access Fill:

Glass Ionomer

Composite

Amalgam

Post and Core

Endodontist's discretion

1. Medication note: Patients who require antibiotic prophylaxis before dental treatment need to take their antibiotics 1 hour prior to their endodontic appointment.

2. Minors: Patients under 18 years of age must be accompanied by a parent or legal guardian.

3. Insurance Note: Patients will be asked to pay their co-insurance amount at time of service.

Remarks: _____
