

# North Shore Endodontic Solutions



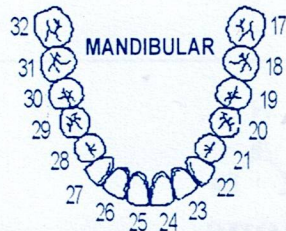
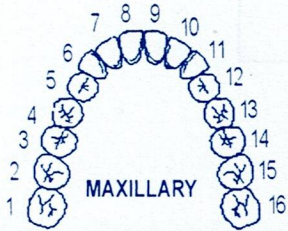
Patient: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Comments / Special Instructions: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

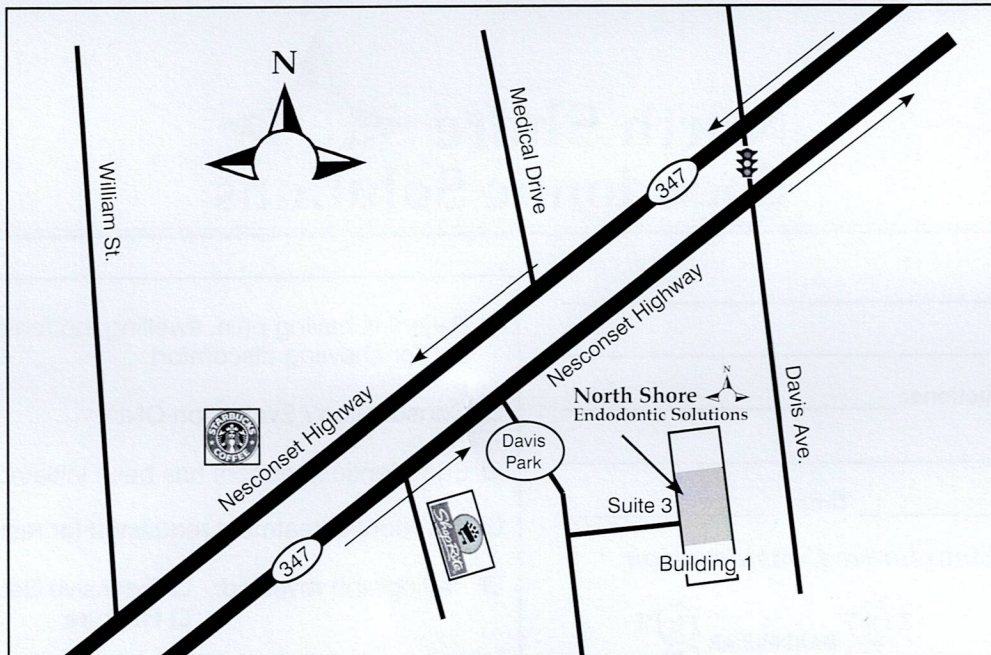
*Circle Tooth for Endodontic Consideration*



- ☐ Patient is having pain, swelling, hot/cold sensitivity and/or chewing discomfort.
- ☐ Consultation / Evaluation ONLY.
- ☐ Endodontic treatment has been initiated.
- ☐ Endodontic treatment requested for restorative purposes.
- ☐ Radiograph revealed:
  - ☐ Extensive Decay
  - ☐ Radiolucency
  - ☐ Fracture
  - ☐ Resorption
- ☐ Please call to discuss case.

**PLEASE BRING THIS TO APPOINTMENT**

Davis Park • 5225 Nesconset Hwy. • Building 1 • Suite 3 • Port Jefferson Station, NY 11776  
(631) 474-ENDO (3636) • Fax (631) 474-3635 • [www.nsendos.com](http://www.nsendos.com)



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