NEW ALBANY
ENDODONTICS
ROOT CANAL SPECIALISTS

Stephen W. Webster Jr., DDS, MS **Kristy L. Bultema, DDS, MS**

Date _____

Patient's Name _____

Referring Dr. _____

PLEASE EMAIL PAs TO AID IN TIMELY SCHEDULING

[Please circle area for endodontic therapy]

RIGHT																**LEFT**
	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 check all that apply:

☐ **Consultation/Evaluation only**
- ☐ Unable to Isolate ☐ Fracture
- ☐ Resorption ☐ CBCT Requested
- ☐ Apicoectomy ☐ Oral Sedation

☐ **Evaluation with Treatment**
- ☐ Initial Root Canal Therapy
- ☐ Retreatment
- ☐ Please prepare Post Space

☐ **Symptoms**
- ☐ Pain ☐ Swelling
- ☐ Decay ☐ Pathology
- ☐ Temperature Sensitivity

☐ **Rx** _____
_____

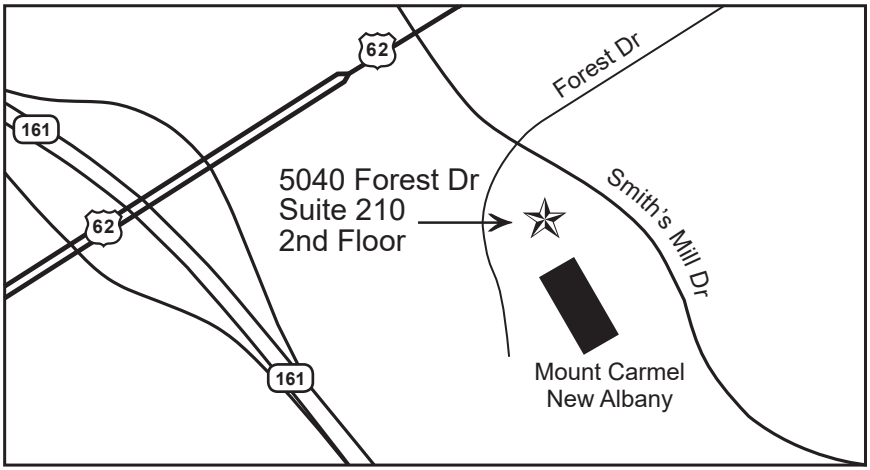
Comments/Additional Notes:

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