



# NEW ALBANY ENDODONTICS

ROOT CANAL SPECIALISTS

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Introducing \_\_\_\_\_

for endodontic consideration on \_\_\_\_\_

**RIGHT** [Please circle area for endodontic therapy] **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

Scheduled Appointment:

Date / Time \_\_\_\_\_

Comments/Additional Notes:

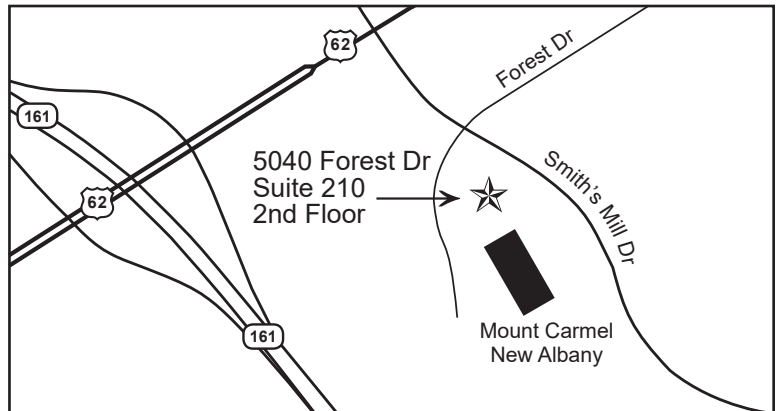
Referring Dr. \_\_\_\_\_

Dr. Phone: \_\_\_\_\_

### Please check all that apply:

- Consultation/Evaluation only**
  - Unable to Isolate     Fracture
  - Resorption     CBCT Requested
- Evaluation and Treatment**
  - Initial Root Canal Therapy
  - Retreatment
  - Please prepare Post Space
- Symptoms**
  - Pain     Swelling
  - Decay     Pathology
  - Temperature Sensitivity
- Rx** \_\_\_\_\_

Learn more prior to your appointment  
and complete your forms online at: [newalbanyendo.com](http://newalbanyendo.com)



Additional comments: