Captain Dental

Endodontics Referral Form

For patients 10 years old and up

4585 Stevens Creek Blvd, Ste 101, Santa Clara , CA, 95051
Tel # 408-826-4676 Email: frontdesk.sc@captaindental.com
www.captaindental.com

INTRODUCING: _____
patient name *date of birth*

Evaluate and Treat Tooth or Area(s)

				A	B	C	D	E	F	G	H	I	J				
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
R	32	31	30	29	28	27	26	25	24	23	22	21	20	19	28	17	L
				T	S	R	Q	P	O	N	M	L	K				

Endodontic Treatment Requested

- ☐ Root Canal Treatment
- ☐ Retreatment of Previous Root Canal
- ☐ Internal Bleaching

Coronal Restoration Requested

- ☐ Post Space
- ☐ Core Build Up
- ☐ Post and Core
- ☐ Temporary Restoration

Medical Considerations: _____

Special Instructions: _____

_____

_____

Referring Doctor: _____
name *date*

Referring Clinic: _____ _____
phone number *email address*

Dear patient,

Welcome to Captain Dental Endodontics services.

Your dentist has referred you for Endodontic evaluation of your tooth, due to a potential root canal issue. At your consultation appointment we will perform a thorough examination and discuss our findings in detail with you. We will discuss your treatment options together.

Please do not take any pain medication 6-8 hours prior to your consultation appointment (if possible). This will increase the accuracy of our testing.