



14215 Spartina Court, Suite 100
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Phone 904.241.0030 • Fax 904.241.6139
www.beachesendo.com

Introducing _____
for Endodontic evaluation of the following tooth (teeth).

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	

TREATMENT DESIRED

- | | |
|--|---|
| <input type="checkbox"/> Evaluate and treat | <input type="checkbox"/> Root resection (Apico) |
| <input type="checkbox"/> Evaluate only | <input type="checkbox"/> Bleaching |
| <input type="checkbox"/> Retreat previously endodontically-treated tooth | |
| <input type="checkbox"/> CBCT Scan | |

STATUS

- | | |
|--|--|
| <input type="checkbox"/> Temperature sensitive | <input type="checkbox"/> Radiographic findings |
| <input type="checkbox"/> Percussion sensitive | <input type="checkbox"/> Deep decay |
| <input type="checkbox"/> Spontaneous aching | <input type="checkbox"/> Pulp exposed |
| <input type="checkbox"/> Swelling | |

DESIRED RESTORATION

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Temporize | <input type="checkbox"/> Prepare post space |
|------------------------------------|---|

Remarks _____

Patient's Appt. on _____ at _____

Referring Doctor _____

Phone # _____

