LAS VEGAS ENDODONTICS

Benjamin J. Barborka, DMD & Associates

Todays Date: _____

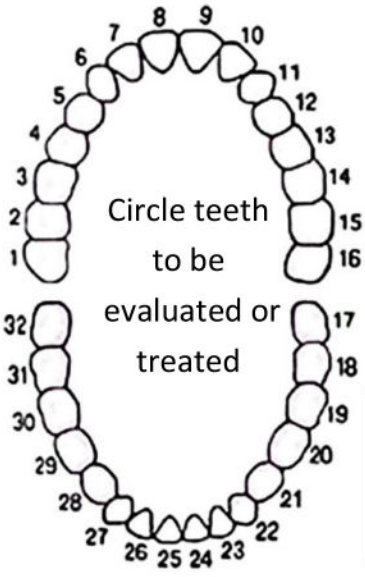
Patient Name: _____

Referred by Dr. _____

Appointment Date:_____

Email Report? Yes____ No_____ Phone #:_____

Email Address: _____



Please Check If Appropriate:

- ◯ ENDODONTIC EXAMINATION ONLY
- ◯ PATIENT HAS PAIN, SWELLING, OR SENSITIVITY- PLEASE TREAT
- ◯ ENDODONTICS NECESSARY FOR RESTORATION
- ◯ EVALUATE FOR PERIAPICAL SURGERY
- ◯ TOOTH HAS HAD PREVIOUS ROOT CANAL TREATMENT
- ◯ PULP EXPOSED
- ◯ LEAVE POST SPACE
- ◯ PLACE FINAL RESTORATION IN ACCESS

CONE BEAM CT SCAN

- ◯ FULL UPPER ARCH
- ◯ FULL LOWER ARCH
- ◯ QUAD: UL LL UR LR

Additional Notes: _____

_____

6655 W. Sahara Ave, Ste A-106 • Phone: (702) 876-5800 • Fax: (702) 876-5923