CENTRAL DENTAL SPECIALTY CENTER

Practice limited to ***Endodontics***

2711 Santa Ana Street
South Gate, CA 90280
Tel: 323.277.0600
Fax: 323.277.0606

Date ______________________

PLEASE BRING THIS CARD TO YOUR APPOINTMENT

Patient Name ____

Appointment Date ______________________________________ AM / PM

Month Day Time

TOOTH NUMBER OR AREA FOR CONSIDERATION

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

☐ Upper Right ☐ Lower Right ☐ Upper Left ☐ Lower Left

Is the tooth treatment planned for a crown restoration? ❑Yes ❑No

COMMENTS

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SERVICE REQUESTED

- ☐ Consultation Only
- ☐ Treat As Needed
- ☐ Root Canal Treatment
- ☐ Root Canal Retreatment
- ☐ Endodontic Surgery
- ☐ Intentional Endodontics For Restorative Reason
- ☐ Assist With Diagnosis
- ☐ Leave Post Space
- ☐ Place Build-Up
- ☐ Place Post & Build-Up
- ☐ Call Prior To Consult/Tx
- ☐ CBCT Scan
- ☐ Other:

REFERRING DENTIST ____

OFFICE PHONE NUMBER ____