CHESAPEAKE DENTAL SPECIALISTS

Farzad Koosha, DDS
Endodontist

Date: _____ Appointment: _____

Patient's Name: _____ Phone: _____

Referred by: _____ Phone: _____

PATIENT IS BEING REFERRED FOR THE FOLLOWING:

Referred for Endodontic Therapy

Tooth # _____

❒ Root Canal Therapy
❒ Re-Treat Root Canal Therapy
❒ Post Removal
❒ Evaluation/Consultation

PLEASE CIRCLE TEETH TO BE TREATED

UPPER

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

LOWER

Comments: _____
_____
_____
_____

❒ Monday ❒ Tuesday ❒ Wednesday ❒ Thursday ❒ Friday

Date: _____ Time: _____

When treatment is complete, please ❒ Restore access opening as needed
❒ Place temporary restoration ❒ Prepare post space ❒ Place post/buildup as needed

If you are unable to keep this appointment, kindly give 24 hours notice.