SOMA Endodontics

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Introducing: _____Date:_____Patient's phone #:_____Email:_____
Referral doctor:_____Email:_____Office's name:_____Office's phone#:_____

Reasons for referral:_____**Tooth number (s):**_____
Please indicate any existing conditions below:

_____**Deep caries. If there is no sign or symptom of irreversible pulpitis or pulp necrosis, please indicate:**
___Please complete caries removal and send the patient back for final restoration if there is no pulp exposure.
___Please complete caries removal and provide prophylaxis root canal treatment before final restoration.

_____Pulp exposure, _____Swelling, and/or _____Pain. Please indicate area/stimulus:_____
_____Trauma. Please indicate type/area:_____
_____Intentional root canal treatment is required for proper restoration.
_____Crown/Bridge. Will the restoration be replaced? ___Yes ___No
_____Existing root canal treatment. Please indicate the treatment date (month/year) if known_____
_____Existing radiograph. Please send to info@soma-endo.com
Special Instructions:_____
_____Leave a space for a post. _____Place a post and a build up. _____Place a build up. _____Place a temporary filling.
_____Please take 3D X-ray/CBCT. Please indicate area/tooth number(s):_____