

**ENDODONTIST INFORMATION**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

**PATIENT DENTAL HISTORY**

Date of Most Recent Periapical and Bitewing Radiograph of Area of Concern: \_\_\_\_\_

Date of Most Recent Bitewing Radiographs: \_\_\_\_\_

Date of Most Recent Full Mouth Series of Radiographs: \_\_\_\_\_

Date of Most Recent Panoramic Radiograph: \_\_\_\_\_

Radiographs have been:  e-mailed to your office  mailed to your office  sent with the patient

**REASON FOR REFERRAL**

Please evaluate the following tooth/teeth for endodontic treatment: \_\_\_\_\_

Status of the Tooth in Question:

Patient has definite toothache and emergency treatment is needed.

Patient has vague discomfort, please evaluate.

Pulp was exposed and needs endodontic treatment.

Treat as indicated.

Please contact Dr. Dillner after consultation.

Other: \_\_\_\_\_

After Treatment:

Provide a core buildup.

Prepare for post.

Other: \_\_\_\_\_

**APPOINTMENT INFORMATION**

- An appointment has been scheduled with your office on \_\_\_\_\_ at \_\_\_\_\_ .
- An appointment was unable to be made, but the patient will be contacting your office to schedule an appointment.
- Please contact this patient for an appointment.

Thank you for providing excellent care to our patient.

If you need any additional information or would like to speak to Dr. Dillner regarding this patient, please contact our office at 620.327.2887.

Thank you for keeping us updated on the patient's progress. Please send any treatment progress reports to: Hesston Dentistry, P.O. Box 250, Hesston, KS 67062 or via e-mail at [office@hesstondentistry.com](mailto:office@hesstondentistry.com).

Sincerely,

Dr. Justin R. Dillner and the Hesston Dentistry Team