WESTCHASE endodontics

MICHAEL E. MASON, *D.M.D., M.S.*

Today's Date:_____

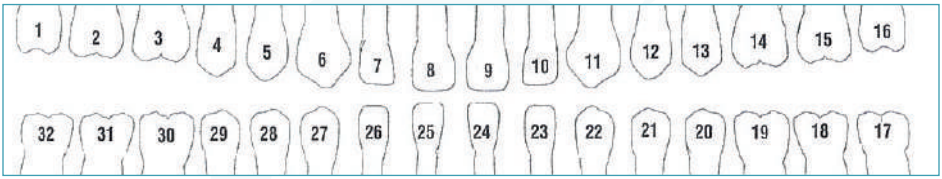
Introducing: (Patient)_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Appointment Time:_____ Date:_____

Referring Doctor:_____ Phone:_____



☐ **Consultation & Diagnosis** ☐ **Emergency Treatment**

☐ **Endodontic Treatment** ☐ **X-ray Revealed Radiolucency**

☐ **Surgical Endodontics** ☐ **3D-CBCT**

Pain:

☐ None ☐ Constant ☐ Spontaneous

Symptoms Include:

☐ Chewing/Percussion ☐ Swelling/Palpation ☐ Hot/Cold Sensitivity

☐ Root Canal Required for Restorative Purposes

Medical History:

☐ Premed Antibiotics ☐ Blood Thinner ☐ Other_____

Post Space: ☐ Yes ☐ No Post/Core: ☐ Yes ☐ No

Remarks:_____

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