

# NORTHEAST ENDODONTICS

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*Diplomate, American Board of Endodontics*

*Practice Limited to Endodontics*

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Introducing \_\_\_\_\_ Date \_\_\_\_\_

Referred By Dr. \_\_\_\_\_

## FOR ENDODONTIC CONSIDERATION

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

SYMPTOMS INDICATE ROOT CANAL TREATMENT NEEDED

OUR PATIENT IS EXPERIENCING PAIN PLEASE EVALUATE

HISTORY OF PULP EXPOSURE

PREVIOUS ROOT CANAL THERAPY

X-RAY REVEALED RADIOLUCENCY

CBCT (3-D X-Ray)

COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Radiographs

- Sent with Patient
- Emailed
- Please Take Necessary X-Rays

### Post Space

- Required
- Not Required

Our office is committed to providing you with the highest quality of care possible. To help us in scheduling your appointment, please remember the following.

1. The initial visit, with the exception of certain emergency cases, may be for consultation only. This enables us to fully evaluate your problems and tailor the care to your specific needs.
2. Patients under eighteen (18) years of age must be accompanied by a parent or legal guardian at the time of the initial consult.
3. Please bring all pertinent medical information and a list of all medications you are currently taking.
4. Insurance is filed as a courtesy to you. We request that you confirm your dental coverage prior to your appointment.

...MAP ON BACK...

