MEDFORD ENDODONTICS

STEVE OSMOND, DDS, MSD

Practice Limited to Endodontics

Date: _____

Introducing: _____ Phone: _____

Referring Dentist: _____

Appointment Date: _____ Time: _____

Please circle the teeth or area that may need treatment.

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

- ☐ Root Canal Therapy as indicated
- ☐ Prepare post space
- ☐ Place class 1 restoration
- ☐ Retreatment case
- ☐ Canals appear blocked
- ☐ Open apex case
- ☐ Bleach
- ☐ Other: _____

- ☐ Surgical Endodontics
- ☐ Apicoectomy & retrofill
- ☐ Root amputation, hemisection, bicuspidization
- ☐ Perforation repair
- ☐ Trauma—fracture, avulsion, replant, splint

- ☐ Examination, Diagnosis, Consultation

Comments: _____

_____

_____

Office: 541 776-7640 • Fax: 541 776-7630 / 541 632-8290
831 Alder Creek Dr. • Medford, OR 97504
www.MedfordEndo.com
medfordrootcanal@gmail.com

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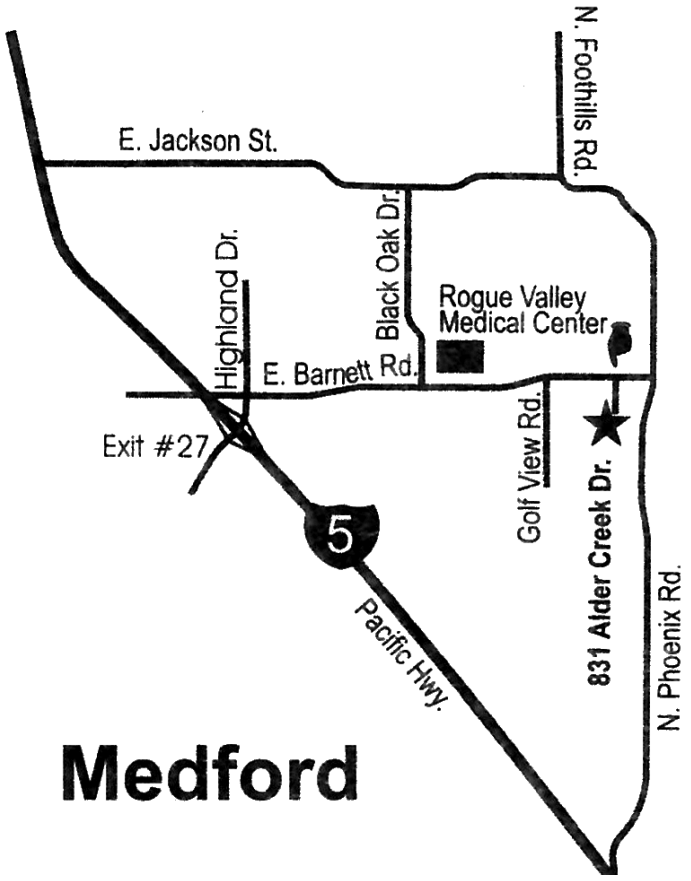
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Instructions to Patients:

1. Please call (541) 776-7640 to arrange your first appointment, if not appointed yet.
2. Minors must be accompanied by a parent or guardian.
3. Endodontic therapy is usually completed in one to two appointments. Each appointment is approximately 1-2 hours.
4. Fees are payable at the completion of your first appointment.
5. Please bring this form with you to the appointment.

For additional information visit www.MedfordEndo.com



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