

PATIENT NAME: _____

REFERRING DOCTOR: _____ TODAY'S DATE: _____

APPOINTMENT DATE: _____ TIME: _____

TOOTH NUMBER OR AREA: _____

REMARKS: _____

PATIENT NEEDS: (Check One)

- Consult Only Root Canal Therapy Evaluate Previous Endo

STATUS: (Check All That Apply)

- Pulp Exposure Percussion Sensitive Deep Decay
 Radiographic Findings Swelling Spontaneous Aching
 Temperature Sensitive Permanent Crown Fracture/Cracked
 Temporary Crown Discomfort Resorption

RESTORATION REQUEST UPON COMPLETION OF RCT: (Check One)

- Temporary Filling Composite Post Space Required
 Post/Core Build Up





ORMOND LOCATION

150 Sage Brush Trail
Ormond Beach, FL 32174
TEL: 386-676-0705
FAX: 386-677-9248

We would like to welcome you to our dental practice and explain a little about our dental goals and our office policies. Our office specializes in root canal therapy (Endodontics). We are committed to saving teeth and make every effort to accomplish this. By choosing endodontic treatment, you are choosing to keep your natural teeth as a healthy foundation for chewing and biting for years to come.

*Please arrive at least **15 minutes** early to complete the medical history and any other paperwork that we need for your chart. If you are under the age of 18, and a new patient, you must be accompanied by a parent or legal guardian.*

INSURANCE: As a courtesy to you, we will file to most insurance plans but are considered out of network. Our professional services are rendered and charged to you in full at the time of treatment. However, if insurance information is provided prior to your treatment and verification is obtained, we will accept the amount the insurance will pay. Any portion of the fee not covered by your insurance is your responsibility. All fees charged via attempts to collect any patient portion will be the financial responsibility of the patient or guardian.

We gladly accept Visa, Master Card, American Express, Discover, Care Credit, personal check, and cash. If you have any questions about our office policy and the charge of treatment please call our office in advance of your appointment.

If you must cancel your appointment, be considerate and allow 24 hours notice.

Sincerely,

Ormond Endodontics