TRI VALLEY ENDODONTICS

HARRISON NGUYEN DDS MSD
JING YE DMD MSD
FLORA TRANG DDS MSD

5720 STONERIDGE MALL RD. #280
PLEASANTON, CA 94588
TEL: 925-469-0875 • FAX: 925-469-0132
TVENDODONTICS@GMAIL.COM

VI DAO DDS
JUSTIN FANG DMD MSD

1034 MURRIETA BLVD.
LIVERMORE, CA 94550
TEL: 925-443-3636 • FAX: 925-443-3655
LIVERMOREENDODONTICS@GMAIL.COM

PATIENT NAME _____

DATE _____

PHONE #S _____

_____

REFERRING DOCTOR _____

○ PATIENT WILL CALL

○ PLEASE CALL PATIENT

MY APPOINTMENT

DATE _____

TIME _____

FOR ENDODONTIC CONSIDERATION OF THE FOLLOWING TEETH:

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

RIGHT LEFT

REFERRED FOR:

- ○ ENDODONTIC TREATMENT AS NEEDED
  - ○ SYMPTOMATIC
  - ○ PULP EXPOSURE
  - ○ REQUIRED FOR PROPER RESTORATION
- ○ ENDODONTIC RETREATMENT
- ○ SURGICAL ENDODONTIC TREATMENT (APICOECTOMY)

ADDITIONAL:

- ○ CONSULTATION ONLY (DO NOT START TREATMENT)
- ○ PLACE BUILD-UP (W/POST IF NEEDED)
- ○ LEAVE POST SPACE
- ○ TREATMENT PLANNED FOR A NEW CROWN OR BRIDGE

COMMENTS: _____

_____

INSTRUCTIONS TO PATIENTS

PLEASE CALL FOR AN APPOINTMENT.
PLEASE BRING A LIST OF ALL THE MEDICATIONS THAT YOU ARE CURRENTLY TAKING.
MINORS MUST BE ACCOMPANIED BY A PARENT OR GUARDIAN.
PAYMENT IN FULL IS REQUIRED ON THE DAY OF THE SERVICE/TREATMENT.

E-MAIL REPORT TO REFERRING DOCTOR AT: _____

WHITE - GIVE TO PATIENT

YELLOW - KEEP IN YOUR PATIENT CHART

AMERICAN ASSOCIATION OF ENDODONTISTS
specialist member