

Patient Name: \_\_\_\_\_

Tooth Number: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Drugs Prescribed: \_\_\_\_\_

Pt. Phone: \_\_\_\_\_

Comments:


Referring Office/Doctor: \_\_\_\_\_



Please Do Not Take any Anti-inflammatory or Pain Medication  
Within 4 Hours of your Consultation Appointment!

**South Sound  
Endodontics**  
253-752-5511

**Gig Harbor  
Endodontics**  
253-851-5544

**Port Orchard  
Endodontics**  
360-443-2424

**Silverdale  
Endodontics**  
360-228-7070

Please submit referrals to: [Team@PugetSoundRootCanals.com](mailto:Team@PugetSoundRootCanals.com)