



— PUGET SOUND —
ENDODONTIC
— ASSOCIATES —

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Today's Date:

Patient Name:

Phone Number:

Birth Date:

Tooth Number:

Date of Last Restoration on Tooth:

Treatment Request:

- | | |
|--|---|
| <input type="checkbox"/> Consultation/Treat as Necessary | <input type="checkbox"/> Apicoectomy |
| <input type="checkbox"/> Root Canal Treatment | <input type="checkbox"/> Internal Bleaching |
| <input type="checkbox"/> Retreatment | <input type="checkbox"/> CBCT Scan |
| <input type="checkbox"/> Please Call referring doctor prior to seeing this patient | |

Comments:

Referring Doctor:

Drugs Prescribed:

Post-Op Care:

- | | |
|---|---|
| <input type="checkbox"/> Restore Access by Endo Office | <input type="checkbox"/> New Crown/Bridge Planned |
| <input type="checkbox"/> Post/Core by Endo Office | <input type="checkbox"/> Post Space Only |
| <input type="checkbox"/> Return patient to Referring Office for Restoration | |

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

FAX: 253-752-4442

FAX: 360-443-2437