



— 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

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