


Alpha Dental Care

Your Smile... Our Passion!

 #500 - 6455 MacLeod Trail SW
Calgary, Alberta T2H 0K9

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Date: _____

Patient Name: _____

Phone Number: _____

Endodontic examination of tooth/teeth numbers: _____

Please evaluate the following conditions/treatments:

- | | |
|---|--|
| <input type="radio"/> Periapical Radiolucency | <input type="radio"/> Retreat Existing RCT |
| <input type="radio"/> Elective Endodontics | <input type="radio"/> Post/File Removal |
| <input type="radio"/> Tooth Accessed - Please Treat | <input type="radio"/> Pulp Exposure - Please Treat |
| <input type="radio"/> Separated Instrument | <input type="radio"/> Calcified Canals |
| <input type="radio"/> Exceptional Canal Only | <input type="radio"/> Other |

Notes: _____

Current Radiograph(s):

- Sent with Patient Emailed Attached No Current X-Ray

Referring Doctor: _____

Have you prescribed any medication? _____