MESQUITE ENDODONTICS

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WWW.MESQUITEENDODONTICS.COM
972-270-4456

Introducing: _____ DOB: _____ Phone: _____

APPOINTMENT

☐My patient needs endodontic treatment on #_____.
root canal—retreatment—apicoectomy—other:
☐My patient may/may not need treatment. Please evaluate.

CONTACT

☐Appointment scheduled for _____.
☐Please call my patient to schedule.
☐My patient will call your office to schedule.

COMFORT

☐Local anesthetic only, no sedation
☐Local anesthetic and
☐ nitrous oxide*
☐ oral sedation*
☐ IV sedation*

*additional fee

CLOSE ACCESS

☐Permanently
☐ Buildup or Post & Core Buildup
☐ Close access through crown
☐Temporary filling
☐Other:

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Treatment plan/Remarks: _____

Referring Dentist: _____

Referring Office: _____

Phone:_____ Fax:_____ Date:_____

☐Fax this form to 972-270-4042

☐Email X-ray(s) to FrontDesk@MesqEndo.com

APPOINTMENT CHECKLIST

☐Forms are available at WWW.MESQUITEENDODONTICS.COM
☐Mesquite Endo has your insurance information
☐Mesquite Endo has your correct phone numbers
☐You know your dentist's name and office phone number
☐You know your physician's name and office phone number
☐You know the names of your prescription medications

ALSO,

☐Wear a short-sleeved shirt
☐Minors must be accompanied by a parent or guardian
☐If you need to bring a companion, please bring only one
☐Give this paper to the Mesquite Endo staff
☐Confirm your appointment ASAP
☐Unconfirmed appointments are promptly canceled

ORAL SEDATION CHECKLIST

ALL THE ABOVE PLUS

☐Wear secure shoes
☐Plan to be at the office for 3-4 hours
☐You must have a ride home
☐No food or drink 6 hours before the appointment