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:

TREATMENT PLAN

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

Appointments are available at www.MESQUITEENDODONTICS.COM

Mesquite Endodontics has your insurance information
Mesquite Endodontics 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
You must bring a companion, please bring only one
You know the names of your prescription medications

APPPOINTMENT CHECKLIST

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
Confirm your appointment ASAP
Unconfirmed appointments are promptly canceled

Fax: 1534 E Interstate 30, Suite 200 GARLAND, TX 75043
www.MESQUITEENDODONTICS.COM
972-270-4456

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APPOINTMENT CHECKLIST

Oral Sedation Check List

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