

# MASON BAHADOR D.D.S.

## ENDODONTIST

Patient: \_\_\_\_\_

Patient phone number: \_\_\_\_\_

Referred by: \_\_\_\_\_

Referral date: \_\_\_\_\_

UPPER

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	

LOWER

- ☐ Evaluation as needed
- ☐ Evaluation only/consult with Doctor before treatment
- ☐ Root canal treatment
- ☐ Retreatment RCT
- ☐ IV Sedation

Does the tooth have a crown ? Yes / No

☐ Provisional    ☐ Permanent

Cemented temporarily or permanently? \_\_\_\_\_

Post space? Yes / No

CBCT Scan: Yes / No

Comments: \_\_\_\_\_

\_\_\_\_\_  
Appointment Day/Time: \_\_\_\_\_

☐ **North Location:**

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