



1550 Cooper Foster Park Road
 Lorain, Ohio 44053
 Phone: (440) 960-2660
 Fax: (440) 960-0180

Thomas A. Montagnese, D.D.S., M.S., F.I.C.D.
 Endodontist
 Sedation Provider

Date: _____ Telephone: _____
 Name: _____
 Address: _____
 Appointment Date: _____ Time: _____

For endodontic evaluation and treatment of tooth number(s)
 (please circle applicable numbers)

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

Patient presents with: (please check appropriate areas)

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Pain during biting |
| <input type="checkbox"/> Pain to hot | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Pain to cold | <input type="checkbox"/> Fever |

Special instructions (Please check where applicable)

- Prepare post space
- Sedation recommended
- Radiographs included
- Type of final restoration planned
- Medications: _____

Referred by: _____

Remarks: _____