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practice limited to conventional and microsurgical endodontics and dental implants
Diplomate of the American Board of Endodontics

Date: _____

Patient's Name: _____

Patient's Phone Number: _____

Referring Dr: _____

Referring Dr's. Treatment plan: _____

- Full-mouth imaging, examination, pulp testing, diagnosis, and consultation
- Limited tooth/area imaging, examination, pulp testing, diagnosis and consultation
- CT Imaging only
- Rule in/Rule out _____

(Circle area or teeth)

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 Requested:**
- Evaluation only Conventional RCT
 - Conventional RCT Re-treatment Microsurgical RCT Re-treatment
 - Implant Replacement:
 - Include Impressions Include Abutment Include Provisional Prosthesis

Comments: _____

- Please call Referring Dr. before presenting treatment plan to patient

OST ENDODONTIC RESTOREATIVE REQUESTS:

losure/Build-up:

- Cavit/Term only Cavit/Term + sponge Bonded composite Bonded Alloy Cast post/core

deal at the orifice: Gutta Percha Cavit Glass Ionomer

ost(s): Canal(s) _____ Post Brand _____ Post Cement _____