EDWIN M. LEVY, D.D.S., CERT. ENDO.
ENDODONTIST

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Date ____________________

Introducing ______________________________________
for Endodontic evaluation of the following tooth/teeth

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
Right															**Left**
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Appointment Date ______________________________

- ❑ Patient has discomfort, please assess
- ❑ Pulp exposed
- ❑ Endodontic therapy has been initiated
- ❑ Endodontic treatment completed - Date __________
- ❑ Restoration is cemented ❑ Temporarily ❑ Permanently
- ❑ Please telephone
- ❑ Post space requested ❑ Parallel ❑ Taper
- ❑ No post space

Comments

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Signed Dr. ______________________________________

WE ACCEPT VISA, MASTERCARD AND DEBIT

WE OFFER NITROUS OXIDE SEDATION.

Our office is wheelchair accessible.

Map on Reverse Side.