ATTLEBORO DENTAL GROUP

Dr. Ammar Awadi
Board-Certified Endodontist

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Patient Name _____ Patient Phone Number _____ Date _____

Referring Doctor _____ Referring Doctor Phone Number _____

Appointment Status: Date _____ Time _____ ☐ Or Patient Will Call to Schedule

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

Reason for Referral

☐ Consultation: _____

☐ Root Canal Therapy: # _____

☐ Endodontic Retreatment: # _____

☐ Endodontic Surgery: # _____

Restoration Considerations

☐ Post Space Requested? Y / N

☐ Sponge and Cavit Temp? Y / N

☐ Complete Core Buildup? Y / N

Diagnostic Information

☐ Percussion? Y / N Thermal? Y / N

☐ Sinus Tract: # _____

☐ Endodontic Care to Facilitate Restorative Care?

Please send recent radiographs.
PAs & BWs of the are, if possible.

Exposure Date: _____

If Antibiotic started - Date & Regimen: _____

Comments: _____

_____

_____

_____

Please have your General Dentist complete this form and email it to our office at frontdesk@attleborodentalgroup.com.
If you do not have a general dentist, please call our office.

Scan for information on our providers and services: