Elite Endodontics

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K. Thurman, D.M.D.
Sara Fayazi, D.D.S., M.S.

Referring Doctor: _____ Date: _____

Patient Name: _____ D.O.B. _____

Address: _____ Phone # _____

Please call patient: _____ **Patient will call to schedule**: _____

X-rays emailed: Y____ N_____ Tooth #(s): _____

Treatment needed:

Exam and consultation: _____ Post/Instrument Removal: _____

Endo for proper restoration: _____ Close with (please circle one): Cavit P&C BuildUp

Root Canal Therapy started: _____ Prepare Post Space _____

Apico and Retro-fill: _____

Additional Instructions/Comments:

_____

_____

_____

_____

Insured Name: _____ Insured Date of Birth: _____

ID# _____Group # _____

Insurance Company: _____ Phone # _____