CLOKEY ENDODONTICS

specialist member
DR. WILLIAM G. CLOKEY

PATIENT'S NAME: _____ DATE: _____

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

REFERRING DOCTOR: _____

CIRCLE TEETH FOR ENDODONTIC CONSIDERATION

UPPER

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

LOWER

ADDITIONAL INFORMATION

- ☐ X-RAY REVEALED RADIOLUCENCY
- ☐ ROOT CANAL TREATMENT WAS STARTED
- ☐ PATIENT IS HAVING PAIN, SWELLING, OR SENSITIVITY
- ☐ ELECTIVE ENDODONTIC TREATMENT NECESSARY
- ☐ EVALUATION FOR APICAL SURGERY
- ☐ RETREATMENT

POST TREATMENT RESTORATION

☐ CORE BUILD-UP ☐ POST AND CORE ☐ PREPARE A POST SPACE ☐ TEMPORARY ONLY

OTHER INSTRUCTIONS

_____

_____

INFORMATION FOR PATIENT

- **TO SCHEDULE, CALL OUR OFFICE AT (256) 563-3005. FOR MORE INFORMATION VISIT CLOKEYENDO.COM.**
- **BRING THIS REFERRAL FORM, VALID ID, AND INSURANCE INFORMATION TO YOUR APPOINTMENT.**
- **HAVE INSURANCE INFORMATION AVAILABLE WHEN SCHEDULING.**

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