



FRIENDLY DENTAL SPECIALTY CENTER  
Practice limited to **Endodontics**

933 S. Sunset Avenue  
Suite 303  
West Covina, CA 91790  
Tel: 626.814.8040  
Fax: 626.814.8620

Date \_\_\_\_\_

**PLEASE BRING THIS CARD TO YOUR APPOINTMENT**

Patient Name \_\_\_\_\_

Appointment Date \_\_\_\_\_ AM  
PM  
Month Day Time

**TOOTH NUMBER OR AREA FOR CONSIDERATION**

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

- Upper Right       Lower Right       Upper Left       Lower Left

Is the tooth treatment planned for a crown restoration?     Yes     No

**COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SERVICE REQUESTED**

- |   |   |
|---|---|
| <input type="checkbox"/> Consultation Only                              | <input type="checkbox"/> Assist With Diagnosis    |
| <input type="checkbox"/> Treat As Needed                                | <input type="checkbox"/> Leave Post Space         |
| <input type="checkbox"/> Root Canal Treatment                           | <input type="checkbox"/> Place Build-Up           |
| <input type="checkbox"/> Root Canal Retreatment                         | <input type="checkbox"/> Place Post & Build-Up    |
| <input type="checkbox"/> Endodontic Surgery                             | <input type="checkbox"/> Call Prior To Consult/Tx |
| <input type="checkbox"/> Intentional Endodontics For Restorative Reason | <input type="checkbox"/> CBCT Scan                |
|   | <input type="checkbox"/> Other                    |

**REFERRING DENTIST**

**OFFICE PHONE NUMBER**

\_\_\_\_\_  
\_\_\_\_\_