ASSOCIATED ORAL SPECIALTIES, INC.

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Multiple Specialties in One Location

DATE: _____

INTRODUCING PATIENT: _____ DOB:_____ PATIENT PHONE: _____

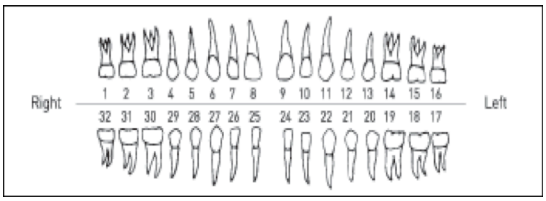
REFERRED BY DR: _____ OFFICE PHONE: _____

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

Requested Treatment
- ☐ Evaluation Only
- ☐ RCT
- ☐ Retreatment
- ☐ Apicoectomy
- ☐ Post Space

History
- ☐ Pain
- ☐ Swelling
- ☐ Bite Sensitivity
- ☐ Pulp Exposure
- ☐ Periapical Lesion
- ☐ Fracture/Crack
- ☐ Trauma
- ☐ RCT Initiated

Please Circle Specific Area of Concern



COMMENTS:_____
_____
_____

Doctors, please fax to 470.428.2686 **BEFORE** giving this form to the patient.