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Patient Name: _____

Patient Telephone: _____
Home Work Cell

Referring Doctor: _____

Please Circle tooth to be treated/evaluated

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

- | Status | Treatment |
|--|---|
| <input type="checkbox"/> Painful | <input type="checkbox"/> Consult Only |
| <input type="checkbox"/> Exposed Pulp | <input type="checkbox"/> Root Canal Therapy |
| <input type="checkbox"/> X-ray Shows Lesion | <input type="checkbox"/> Retreatment |
| <input type="checkbox"/> Previous Root Canal | <input type="checkbox"/> Apicoectomy |

COMMENTS:

DOES THIS PATIENT NEED TO BE PRE-MEDICATED? _____
 IS THIS A PATIENT IN GOOD STANDING? _____
 HAS THIS TOOTH RECENTLY HAD TX? _____