THE ENDODONTIC OFFICE

Root Canal Therapy & Dental Pain Management

Doctor: _____

Appointment

Date: _____

Time: _____

CONSULTATION HOURS:

Mon - Fri: 9 am to 6 pm
Sat : 9 am to 4 pm

appointment@endooffices.com
www.endooffices.com

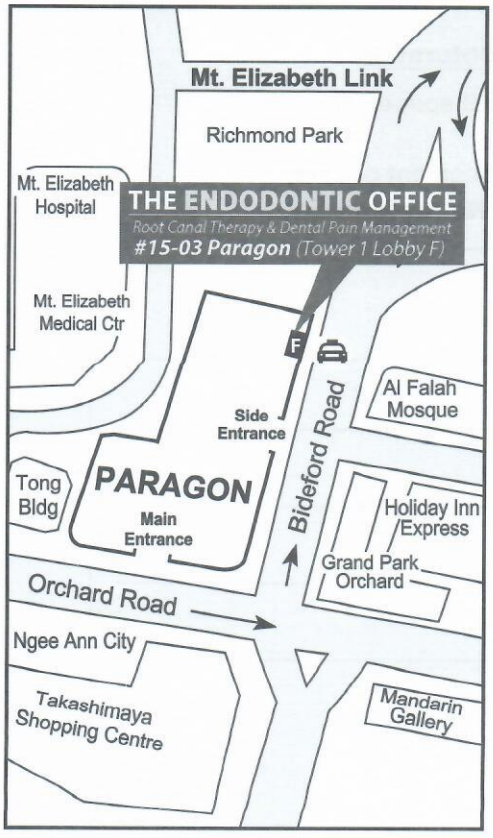
☐ **Orchard**
290 Orchard Road
#15-03 Paragon
(Tower 1 Lobby F)
Singapore 238859
Co. Reg. No: 200701900K
Tel (65) **6734 7790**
Fax (65) **6734 7736**

☐ **Novena**
101 Irrawaddy Road
#18-01/02/06
Royal Square @ Novena
Singapore 329565
Co. Reg. No: 201328289K
Tel (65) **6259 3100**
Fax (65) **6259 3085**

☐ **Jurong East**
2 Venture Drive
#01-05
Vision Exchange
Singapore 608526
Co. Reg. No: 202034701C
Tel (65) **6874 7790**
Fax (65) **6874 7798**

Restricted Practice

Orchard
290 Orchard Road
#15-03 Paragon *(Tower 1 Lobby F)*
Singapore 238859



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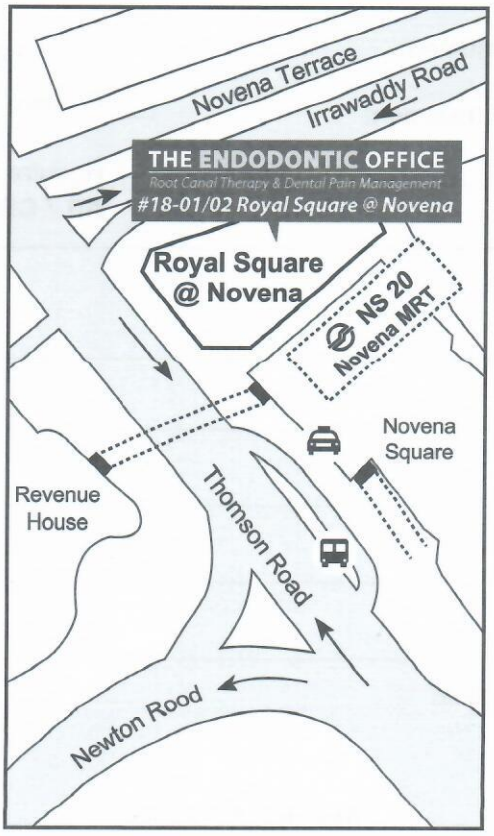

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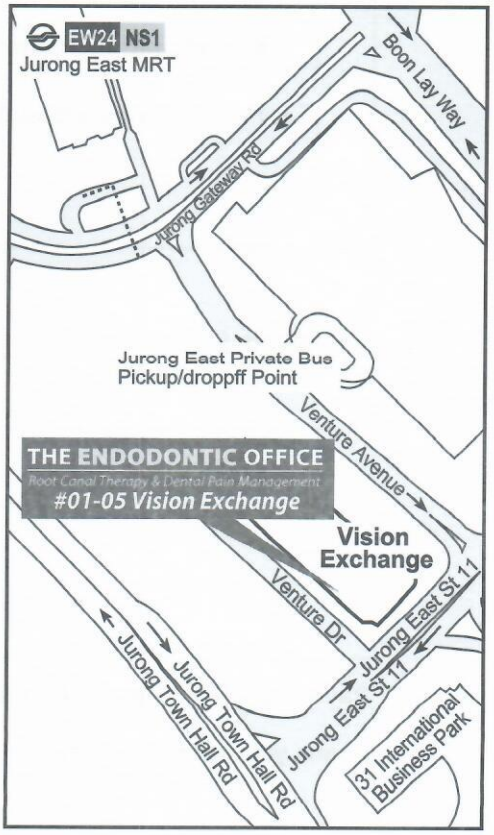

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Root Canal Therapy & Dental Pain Management

Date of Referral: _____

Referring Doctor

Doctor: _____ Phone: _____

Clinic: _____

Patient Particulars

Name: _____

Phone: (H) _____ Email: _____

(M) _____

Tooth Concerned : _____

Clinical Findings

- ☐ Pain / Swelling / Sinus tract
- ☐ Carious pulp exposure
- ☐ Endodontic treatment initiated
- ☐ For elective endodontic treatment

Treatment Requested

- ☐ Consultation only
- ☐ Examination and treatment

Post Obturation

- ☐ Prepare post space only
- ☐ Require placement of core: **AR / CR / No preference**

Comments / Remarks: _____

Payment: Bill Patient / Bill Clinic

Thank you for your referral.

Restricted Practice