VALLEY ENDODONTICS

BRIAN L. WILSON, DMD, PC
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2350 NW Century Drive, Suite 200 • Corvallis, OR 97330
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Patient: _____ Date: _____

Referring Doctor: _____ Patient Phone: _____

Tooth # (Area) _____ Patient Birthdate: _____

☐ **Evaluation and Consultation:**

☐ Orofacial Pain Symptoms ☐ Tooth Restorability ☐ Botox Therapeutics ☐ Other (below)

☐ **Evaluation and Endodontic Therapy as Indicated:**

☐ Root Canal Therapy ☐ Retreatment Therapy ☐ Resorption Repair
☐ Root-End Surgery ☐ Pulp Regeneration ☐ Other _____

Restorative Requests:

☐ Temporize Access ☐ Prepare Post Space
☐ Permanently Restore Access ☐ Place Post & Core

☐ **Evaluation and Dental Implant Therapy as Indicated**

☐ **Patient Sedation Indicated:** ☐ Oral ☐ Nitrous ☐ IV ☐ General

☐ **Antibiotic Pre-medication Indicated**

Radiographs: ☐ Sent with patient ☐ Sent by mail ☐ Sent by email

Comments: _____

Appointment Information

Date: _____ Time: _____

This time is reserved specifically for you. If by necessity you must cancel your appointment, please notify us at least 24 hours in advance.

Our office reserves daily emergency appointments to provide initial care for people experiencing severe pain or infection. Please let us know if your patient's condition requires immediate care so we may schedule them appropriately.

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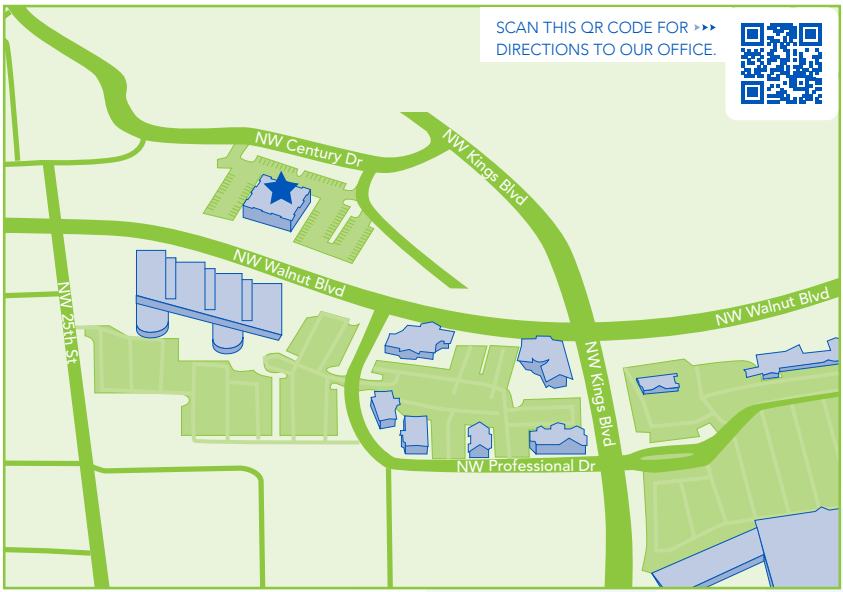

Please assist us by providing the following information at the time of your consultation:

- Your treatment referral slip and any x-rays if applicable.
- A list of medications you are currently taking.
- If you have dental insurance, please provide us the following insurance information: Name of the insurance company, policy holder's name and employer, insurance I.D. number or social security number, date of birth of policy holder and the date of birth of the patient.

IMPORTANT:

All patients under the age of 16 must be accompanied by a parent or guardian at all appointments.

X-RAYS:

If your dentist has taken x-rays of the area in question, please bring them with you to your appointment.